

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>2 months</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto. City</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> STREET ADDRESS <u>135 N. Broadway</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Salvatore</u> (First) <u>Acosta</u> (Middle) <u>Agustina</u> (Last)		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>51</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>unknown</u>	8. DATE OF BIRTH <u>9/4/03</u>	9. AGE last birthday <u>47</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Canary Islands</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>051-18-2893</u>		17. INFORMANT AND ADDRESS <u>Hospital records</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute cardio respiratory failure secondary to

INTERVAL BETWEEN ONSET AND DEATH  
24 hours

Antecedent cause(s)

(b) cardiac hypertrophy and dilatation secondary to

2 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) generalized arterosclerosis

unknown

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

syphilis

unknown

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 11/16....., 1950., to 2/9/51....., 1951., that I last saw the deceased

alive on 2/9....., 1951., and that death occurred at 3:00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>2-21-51</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Grove State Hosp.</u>		LOCATION (City, town, or county) <u>Catonsville 28, Md.</u>		(State)
---	--	--	--	--	--	---------

DATE REC'D BY LOCAL REG.  
2-21-51

REGISTRAR'S SIGNATURE  
V. E. Harry

24. FUNERAL DIRECTOR

ADDRESS  
Spring Grove State Hospital, Catonsville 28, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

673546



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **KX**

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Port Howard, Md.</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vets. Adm. Hosp. Ft. Howard, Md.</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>no home</b> TOWN <b>no home</b> STREET ADDRESS (If rural, give location) <b>no home</b>	
3. NAME OF DECEASED (Type or Print) <b>RAYMOND E. ALMONY</b>		4. DATE OF DEATH <b>Feb. 27 1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>1-3-22</b>
9. AGE last birthday <b>29</b> yrs.		10. AGE last birthday <b>29</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>exercise boy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Race track</b>	
11. BIRTHPLACE (State or foreign country) <b>Monkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clarence Almony</b>		14. MOTHER'S MAIDEN NAME <b>Niabree + Mabrey ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>103</b> (If yes, give war or dates of service) <b>WAC-2</b>		16. SOCIAL SECURITY No. <b>unknown</b>	
17. INFORMANT AND ADDRESS <b>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</b>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Tuberculosis, pulmonary, far advanced</b>	<b>6 months</b>
Antecedent cause(s) (b) <b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b>	<b>Plus</b>
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb. 20**, 19**51**, to **Feb. 27**, 19**51**, that I last saw the deceased **alive on Feb. 27, 1951**, and that death occurred at **10:30 A** m., from the causes and on the date stated above.

SIGNATURE **Paul Padgett** (Degree or title) ADDRESS DATE SIGNED

**PAUL PADGETT, M.D. CHIEF, MEDICAL SERVICE VAN FORT HOWARD, MD.** 2-27-51

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Mar 2, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>	LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
DATE REC'D BY LOCAL REG <b>2/28/51</b>	REGISTRAR'S SIGNATURE <b>Paul Padgett</b>	24. FUNERAL DIRECTOR ADDRESS <b>Blight Funeral Home 6009 Harford Rd. Balto. Md.</b>	

**Mildred J. Blight** 091859

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15-1

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1235 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
TOWN <u>Catonsville</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>6214 - Frederick - Road</u>	
3. NAME OF DECEASED (Type or Print) <u>KATIE</u> (First) <u>ANDREWS</u> (Last)		4. DATE OF DEATH <u>FEB. 2</u> (Month) <u>1951</u> (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 9 - 1861</u>
9. AGE last birthday <u>89</u> yrs.	10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	11. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
12. FATHER'S NAME <u>James Charles</u>		13. MOTHER'S MAIDEN NAME <u>Mary E. Mills</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		15. SOCIAL SECURITY No. <u>None</u>	
16. INFORMANT <u>Mrs. L. D. Rudisill</u>		17. ADDRESS <u>6214 - Frederick - Ave</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>MYOCARDITIS, CHRONIC.</u>			
Antecedent cause(s) (b) <u>SENILITY</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 18</u> , 19 <u>48</u> , to <u>Feb 2</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>51</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. Lloyd Johnson M.D.</u>		ADDRESS <u>Catonsville, Md.</u>	
DATE SIGNED <u>2/3/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 5/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Bowdon Park Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/5/51</u>		REGISTERAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Charles J. Schwab</u>		ADDRESS <u>3512 - Frederick - Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1236

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>VICTORY VILLA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>VICTORY VILLA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 RUNWAY COURT</u>		STREET ADDRESS (If rural, give location) <u>1 RUNWAY COURT</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MILTON</u>	(Middle) <u>E.</u>	(Last) <u>ANDREWS</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV. 6, 1859</u>
9. AGE last birthday <u>91</u> yrs.		4. DATE OF DEATH <u>FEB. 26</u> 19 <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. - GROCERY STORE OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>REV. MILTON E. ANDREWS</u>		14. MOTHER'S MAIDEN NAME <u>KEZIAH ARNOLD</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MRS. MARGARET ANDREWS, 1 RUNWAY COURT</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
156.1 Immediate cause (a) <u>Cancer of the Liver</u>			<u>4 months</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>			
93d Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>old age</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov-8</u> , 19 <u>50</u> , to <u>Feb-15</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Feb-15</u> , 19 <u>51</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Wm. Cook M.D.</u>		ADDRESS <u>901 Funelage Cr Baltimore Md</u> DATE SIGNED <u>2/26/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>REMOVAL</u>		DATE THEREOF <u>2/27/51</u>	
NAME OF CEMETERY <u>MT. HERMAN</u>		LOCATION (City, town, or county) (State) <u>CAMEL COUNTY, VIRGINIA</u>	
DATE REC'D BY/LOCAL REG. <u>2/27/51</u>		REGISTRAR'S SIGNATURE <u>AW Medical</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 ST. PAUL ST.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1237  
 Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Balto</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Owings Mills</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Owings Mills</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Sunset Road</b>		STREET ADDRESS (If rural, give location) <b>Sunset Road</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Hannah</b>	(Middle) <b>Elizabeth</b>	(Last) <b>Arendt</b>
4. DATE OF DEATH	(Month) <b>Feb.</b>	(Day) <b>21</b>	(Year) <b>51</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Mch. 12, 1867</b>
9. AGE last birthday <b>83</b> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	13. FATHER'S NAME <b>Charles Smith</b>	14. MOTHER'S MAIDEN NAME <b>Sarah Neal</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>
16. SOCIAL SECURITY No. <b>None</b>	17. INFORMANT AND ADDRESS <b>Mrs. Lester Brown, Owings Mills, Md.</b>	18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Coronary Artery Disease</b>		<b>1 year</b>
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Hypertensive C.-V. Disease</b>		<b>9 yrs.</b>
93d		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <b>None</b>		
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>None</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>	PLACE (Home, farm, factory, street, or office bldg., etc.) <b>None</b>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>None</b>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <b>Not an injury</b>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <b>Rep. M.D. 2.2. Caples Exam</b>	ADDRESS <b>6 Hanover Road, Belisterstown, Md.</b>	DATE SIGNED <b>2-22-51</b>
23. BURIAL, CREMATION OR REMOVAL (Specify) <b>B.</b>	DATE THEREOF <b>Feb. 24, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>
LOCATION (City, town, or county) <b>Pikesville</b>	24. FUNERAL DIRECTOR <b>Wm. Berryman &amp; Son</b>	ADDRESS <b>Belisterstown</b>
DATE REC'D BY LOCAL REG. <b>2-22-51</b>	REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WEDGEM

WEDGEM



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No. **1238** **83**

1. PLACE OF DEATH COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Fullerton</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Fullerton</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7529 Belair Rd.</b>		STREET ADDRESS (If rural, give location) <b>7529 Belair Rd.</b>	
3. NAME OF DECEASED (Type or Print) <b>Charles Hilbert Arthur</b>		4. DATE OF DEATH (Month) <b>Feb</b> (Day) <b>19</b> (Year) <b>1951</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>single</b>	8. DATE OF BIRTH <b>July 22, 1887</b>
9. AGE last birthday <b>63 yrs.</b>		10. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
13. FATHER'S NAME <b>James Arthur</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Redding</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>Mrs. Eva L. Ostigren - 920 W. North Ave.</b>	
17. INFORMANT <b>Mrs. Eva L. Ostigren - 920 W. North Ave.</b>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Coronary occlusion</b>		<b>Immediate</b>	
Antecedent cause(s) (b) <b>420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying causa last</b>			
Other significant conditions (c) <b>940</b>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	
(CITY OR TOWN) (COUNTY) (STATE)		HOW DID INJURY OCCUR?	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <b>D. McEarmore M.D.</b>		DATE SIGNED <b>2/19/51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>	
DATE THEREOF <b>2/21/51</b>		LOCATION (City, town, or county) <b>Balto., Md.</b>	
DATE REC'D BY LOCAL REG. <b>2/21/51</b>		24. FUNERAL DIRECTOR <b>Wm. J. Schner &amp; Sons - Balto., Md.</b>	
REGISTRAR'S SIGNATURE <b>d w. Redman</b>		ADDRESS <b>490 VV</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 49

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Huntington Valley</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>Pine Road</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) <u>ALFRED</u> (Middle) <u>BAITINGER</u> (Last)		4. DATE OF DEATH <u>February 4</u> (Month) <u>4</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-15-26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	9. AGE last birthday <u>24</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Baitinger</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Kramer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>MALIGNANT MELANOMA, METASTATIC TO LUNGS, LIVER KIDNEYS, SPLEEN, LYMPH NODES AND SKIN</u>		<u>3 1/2 YEARS</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 10, 1951, to Feb. 4, 1951, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE Walter R. Benson (Degree or title) ADDRESS VAH Fort Howard, Maryland DATE SIGNED 2-4-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>2/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>Lawnview Cemetery</u>	LOCATION (City, town, or county) (State) <u>Rockledge, Penna.</u>
DATE REC'D BY LOCAL REG. <u>2/5/51</u>	REGISTRAR'S SIGNATURE <u>R. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Mildred J. Blythe</u>	ADDRESS <u>6009 Harford Road, Balto., Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1240 37

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gopals Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Tufts Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>Edward</u> (Middle) <u>BAREHAM</u> (Last)		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>1-18-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Servant</u>	9. AGE last birthday <u>72</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto Co. Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Aguilla Bareham</u>		14. MOTHER'S MAIDEN NAME <u>Aminda Fisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Wm. Bareham, Cockeysville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Arteriosclerotic Heart Disease.</u>	<u>2 yrs.</u>
Antecedent cause(s)	(b) <u>Generalized arteriosclerosis.</u>	<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Hypertrophied Heart.</u>	<u>2 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>Duodenal Ulcer</u>	<u>2 yrs.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June....., 1940, to 2-9-....., 1951., that I last saw the deceased alive on 2-9-....., 1951., and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE Robert H. Hine (Degree or title) ADDRESS M.D. 3105 N. Charles St. Balto. 18. Md. DATE SIGNED 2-9-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-12-1951</u>	<u>St. Ignace</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2/12/51</u>	<u>Wm. J. Chilcoat</u>	<u>L. J. Brooks</u>	<u>Sparks, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Farmersburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Holiday House</u>		STREET ADDRESS (If rural, give location) <u>333 N. Charles St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MARGARET</u> (Middle) (Last) <u>BARGAR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 19 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>August 30, 1865</u>
9. AGE last birthday <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSIC TEACHER</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Bargar</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Anderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Miss Katharine Magness - 1362 Homestead St</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Carcinoma of Breast

INTERVAL BETWEEN ONSET AND DEATH

3 years

## Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

1949Cancer of Breast

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1950, to Feb 19, 1951, that I last saw the deceasedalive on 2-17-51, 1951, and that death occurred at 8:40 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Maurice C. Porterfield M.D.1 Hampstead, Md2/19/51

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/20/51A. W. HenschThos. J. Lickner & Sons - Balto057888 Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1242

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Opitz Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>3611 Spaulding Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary</u> <u>M.</u> <u>Barnes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb</u> <u>2</u> <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 25, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
13. FATHER'S NAME <u>Theodore</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Dophamon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Mary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs</u> <u>10 yrs</u> <u>2 yrs</u>
Immediate cause (a) <u>Pneumonia, acute</u>			
Antecedent cause(s) (b) <u>Semantic degeneration, senile; atrophic</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Alcoholism</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 1940, to Feb. 2, 1957, that I last saw the deceased alive on Jan. 25, 1957, and that death occurred at 2 1 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb 5, 1957</u>	<u>Catharine</u>	<u>Baltimore</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/5/57</u>	<u>A. W. Hedman</u>	<u>Loring Byers</u>	<u>5005 Park Heights</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1243

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gwynn Oak Uplands</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gwynn Oak Uplands</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5300 Gwynndale Ave.,</u>		STREET ADDRESS (If rural, give location) <u>5300 Gwynndale Ave.,</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Martha Washington Bartholome</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 21, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 27, 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>---</u>	
13. FATHER'S NAME <u>Jurant Baker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary T. Terry 5300 Gwynndale Ave.,</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>3rd infarction of eye</u>		<u>2 yrs</u>
442X Antecedent cause(s) (b) <u>Arteriosclerosis Cardio Vase Renal</u>		<u>8 yrs</u>
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to Feb 21, 1951, that I last saw the deceased alive on Feb 20, 1951, and that death occurred at 1 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>2-23-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Paran</u>	LOCATION (City, town, or county) (State) <u>Harrisonville, Md.</u>
DATE REC'D BY LOCAL REG. <u>2/23/51</u>	REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>	24. FUNERAL DIRECTOR ADDRESS <u>G. Howard Strong 3207 W. North Ave.,</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence for addition  
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1244

FILM No. G 13 CFEB 14 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> TOWN STREET ADDRESS (If rural give location) <u>2924 CORNWALL RD</u>	
3. NAME OF DECEASED (Type or Print) <u>CORRIE</u> (First) <u>BEAMAN</u> (Middle) (Last) 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u> 8. DATE OF BIRTH <u>DEC 15/1860</u> 9. AGE last birthday <u>90</u> yrs. If under 1 year Months Days Hours Min. If under 24 hrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>SOUTH CAROLINA</u> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>NEAL ANDREWS</u> 14. MOTHER'S MAIDEN NAME <u>EMILY MC KNIGHT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY No. <u>-</u> 17. INFORMANT <u>MRS DORA WELSH - 2924 CORNWALL RD</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334x Immediate cause (a) Cardiac Failure  
97 Antecedent cause(s) (b) Senility  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Generalized and coronary arteriosclerosis (2/13/51 akc)

INTERVAL BETWEEN ONSET AND DEATH 2 days

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 1948, to....., 1951., that I last saw the deceased alive on 31 Jan, 1951., and that death occurred at 2 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) REMOVAL DATE THEREOF 2/2/51 NAME OF CEMETERY OR CREMATORY FRIENDSHIP LOCATION (City, town, or county) GREEN S. C. (State)

DATE REC'D BY LOCAL REG. 2/2/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

ULLRICH FUNERAL HOME DUNDALK MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

## MEDICAL CERTIFICATION

BIRTH NO. 8				SIGNED ON: FEB 19 1951				2. DATE OF DEATH 2-12-51			
1. NAME OF DECEASED (Type or Print) MELVINA (MIKALINA) BENDER				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) 2305 H. Maryland				B. COUNTY Baltimore			
3. PLACE OF DEATH: A. Baltimore City, Maryland				C. CITY OR TOWN (If outside corporate limits, write KURAT, and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 2305 Harlem Ave.			
B. FULL NAME OF (If not in hospital or institution, give street address or location) House of the Pine Catonsville				5. SEX F.				6. COLOR OR RACE White			
c. Length of stay in Baltimore 357				7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed				8. DATE OF BIRTH 3/23/1892			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years, last birthday) 59 58			
13. FATHER'S NAME Unknown				11. BIRTHPLACE (State or foreign country) Lithuania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO.				14. MOTHER'S MAIDEN NAME Unknown			
17. INFORMANT George Bender				ADDRESS Holms St				INTERVAL BETWEEN ONSET AND DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Carcinoma Brain				DUE TO			
193X ANTECEDENT CAUSES				(B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				5.12 Brunch pneumonia				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 3, 1951, to Feb 12, 1951, that I last saw the deceased alive on Feb 12, 1951, and that death occurred at m., from the causes and on the date stated above.											
23A. SIGNATURE M. D. M. D. 1429 N. Fayette St.				23B. ADDRESS 1429 N. Fayette St.				23C. DATE SIGNED Feb 13, 1951			
24A. BURIAL, CREMATION, REMOVAL (Specify) Buried				24B. DATE 2/16/51				24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer			
24D. LOCATION (City, town, or county) Belair Rd				24E. FUNERAL DIRECTOR Charles W. Schuchman				24F. ADDRESS 703 Mc Henry St.			
DATE RECEIVED BY LOCAL REGISTRAR 2/18/51				REGISTRAR'S SIGNATURE R. W. Hedrick							



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1246

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
TOWN <u>Catonsville</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2318 Powers Lane</u>		STREET ADDRESS (If rural give location) <u>2318 Powers Lane</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>James</u> (Middle) <u>Albert</u> (Last) <u>Bearley</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>1</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-10-67</u>
9. AGE last birthday <u>83</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Small job</u>	
13. FATHER'S NAME <u>Isaac J. Bearley</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Kaiser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Barbara Smith Cate</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4201 Immediate cause (a) Crownary occlusion  
 94a Antecedent cause(s) (b) giving rise to the above cause stating the underlying cause last  
 (c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb. 3, 1957</u>	<u>New Cathedral Cemetery</u>	<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2-3-51</u>	<u>V. E. Harry</u>	<u>Easton Road</u>	<u>Catonsville 28, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>522 N. Rose Street</u> TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or Print) <u>MARGARET</u>		4. DATE OF DEATH <u>February 17, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 14, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>	9. AGE last birthday <u>77</u> yrs. <u>3</u> Months <u>3</u> Days
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles Bodine</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Frank</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records, Catonsville 28, Md.</u>	

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause (a) <u>Pneumonia, both lower lobes</u>		<u>4 days</u>
108 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive cardio-vascular disease</u>		<u>Unknown</u>
		<u>Unknown</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>At work</u> INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 15, 1951, to Feb. 17, 1951, that I last saw the deceased alive on Feb. 16, 1951, and that death occurred at 12:15 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL OR CREMATION (Specify) <u>Burial</u>	DATE THEREOF <u>3/1/51</u>	NAME OF CEMETERY OR CREMATORY <u>Balto.</u>	LOCATION (City, town, or county) <u>Balto. Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2-28-51</u>	REGISTRAR'S SIGNATURE <u>A W Hedrick</u>	24. FUNERAL DIRECTOR <u>4174 Cook Inc. 1217 St. Paul St</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1247

1043846

# MARYLAND STATE DEPARTMENT OF HEALTH

Evidence change item 8 on

2411 N. Charles Street, Baltimore

1248

38

Form No. G 131 FEB 23 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>BALTO CO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>3043 Putty Hill Ave</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>3043 Putty Hill Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3043 Putty Hill Ave</u>		STREET ADDRESS (If rural, give location) <u>3043 Putty Hill Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Herbert</u>	(Middle)	(Last) <u>Bowman</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 16 - 1888</u> AGE last birthday <u>66 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co</u>	11. BIRTHPLACE (State or foreign country) <u>PA</u>
13. FATHER'S NAME <u>Chas. P. Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>213-07-7576</u>	17. INFORMANT AND ADDRESS <u>Mr. Herbert C. Bowman 3041 Putty Hill Ave</u>

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Coronary Occlusion

##### INTERVAL BETWEEN ONSET AND DEATH

10 min

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Severe myocarditis, Ventricular block

4 Month

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 2, 1951, to Feb 9, 1951, that I last saw the deceased

alive on Feb 9, 1951, and that death occurred at 7:25 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Harold H. Burns

7952 Harford Rd

Parkville MD 2/10/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2/13/51</u>	<u>Parkwood Cem</u>	<u>BALTO</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/12/51</u>	<u>G.M. Bacon</u>	<u>Lassahn Funeral Home</u>	<u>7401 Belair Rd</u>	

544246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

529 N. Charles  
Dr. H. Burns

2823 Linwood



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fallston, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u> (Middle) <u>W.</u> (Last) <u>BRADFORD</u>	4. DATE OF DEATH (Month) <u>February</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Wid.</u>	8. DATE OF BIRTH <u>9-28-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Smart Farmer</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam Bradford</u>		14. MOTHER'S MAIDEN NAME <u>Rosa ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Hospital records</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute myocardial failure

INTERVAL BETWEEN ONSET AND DEATH

24 hours

Antecedent cause(s)

(b) Arterio sclerotic cardio-vascular dis.

indef.

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1949, to Febr. 24, 1951, that I last saw the deceased

alive on Febr. 24, 1951, and that death occurred at 9:50 P.m., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

Abraham M. Schneidmuhl, M.D.

Spring Grove Hospital

Febr. 24, 1951

#### 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/25/51

V. E. Barry

H. Madison Mitchell

970115 Harford Co., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



RECEIVED  
FEB 28 1951  
BL 2540 7 8

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12550

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS <u>501 S. Rappolla St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Catherine</u> (First) (Middle) (Last) <u>Brady</u>		4. DATE OF DEATH <u>2</u> (Month) <u>28</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 1878</u> 9. AGE last birthday <u>72</u> yrs. <u>10</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Romple</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cardio respiratory failure</u>		
Antecedent cause(s) (b) <u>Ischemic cardiovascular disease</u>		Indef.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized arteriosclerosis</u>		Indef.
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>11/18</u> , 19 <u>50</u> , to <u>2/28</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>2/28</u> , 19 <u>51</u> , and that death occurred at <u>9</u> <u>a</u> .m., from the causes and on the date stated above.		
SIGNATURE <u>Sara E. Bennett</u> (Pegree or title) <u>Sara E. Bennett, M.D.</u>		ADDRESS <u>Spring Grove Hospital</u> DATE SIGNED <u>2-28-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cem.</u> LOCATION (City, town, or county) <u>Balto. Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>3-2-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>John A. Moran</u> ADDRESS <u>3000 E. Balto. St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1251 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Sellers Point Road</u>		STREET ADDRESS (If rural, give location) <u>616 J STREET</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MARY</u> (Middle) <u>Holmes</u> (Last) <u>BRAXTON</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>27</u> (Year) <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Color</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>October 8, 1892</u>
9. AGE last birthday <u>58 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitorial</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>James FULKS</u>		14. MOTHER'S MAIDEN NAME <u>Elvira Holmes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>219 22 1207</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ella Mae Watkins 616 J St. S. P. Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Respiratory Failure</u>		<u>15 mins</u>
(b) Antecedent cause(s) <u>Broncho-Pneumonia</u>		<u>24 hours</u>
(c) <u>Carcinoma of Right Breast @ Carcinoma of Cervix</u>		<u>2 mths - 14 wks</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION <u>March 11, 1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Right Breast - Mastectomy (Right) March 11, 1950</u>	
21. ACCIDENT SUICIDE HOMICIDE <u>NONE</u>	22. PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>No INJURY</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 10, 1950, to February 24, 1951, that I last saw the deceased alive on February 24, 1951, and that death occurred at 9:40 a.m., from the causes and on the date stated above.

SIGNATURE <u>William C. Hale, M.D.</u>	(Degree or title)	ADDRESS <u>140 Oak Avenue Dundalk Md.</u>	DATE SIGNED <u>February 27, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Mary</u>	LOCATION (City, town, or county) <u>A. J. Co.</u>
DATE REC'D BY LOCAL REG. <u>2/26/51</u>	REGISTRAR'S SIGNATURE <u>R. W. Redlich</u>	24. FUNERAL DIRECTOR <u>Samuel W. Sullivan Jr.</u>	ADDRESS <u>Balto.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

770246

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1252

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <b>Balto</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md</b> COUNTY <b>Balto</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Balto Co</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Balto Co</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Belair Rd Perry Hall</b>		STREET ADDRESS (If rural give location) <b>Belair Rd Perry Hall Fullerton Po</b>	
3. NAME OF DECEASED (Type or Print) <b>Walter</b>	(First) <b>W</b> (Middle) <b>Bright</b> (Last)	4. DATE OF DEATH (Month) <b>Feb</b> (Day) <b>4</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec 8 1888</b>
9. AGE last birthday <b>62</b> yrs.		10. AGE last birthday If under 1 year: Months <b>4</b> Days <b>4</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G L Martin</b>	
11. BIRTHPLACE (State or foreign country) <b>PA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Paul Bright</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hampson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY No. <b>204-12-5879</b>	
17. INFORMANT <b>Mrs W W Bright Belair Rd. Perry Hall, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <b>Coronary thrombosis</b>		
(b) <b>Antecedent cause(s)</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 8**, 19**51**, to **Feb. 4**, 19**51**, that I last saw the deceased alive on **Feb. 4**, 19**51**, and that death occurred at **11:20 A.M.** m., from the causes and on the date stated above.

SIGNATURE <b>Adame Gleavis</b>	(Degree or title) <b>M.D.</b>	ADDRESS <b>6222 Belair Road, Balto 6, Md</b>	DATE SIGNED <b>Feb. 5, 1951</b>
23. BURIAL, CREMATION, REMOVAL. (Specify) <b>Burial</b>	DATE THEREOF <b>2-7-1951</b>	NAME OF CEMETERY OR CREMATORY <b>Dimmore Cem Scranton PA</b>	LOCATION (City, town, or county) (State) <b>Scranton PA</b>
DATE REC'D BY LOCAL REG. <b>2/4/51</b>	REGISTRAR'S SIGNATURE <b>W. M. Hammert</b>	24. FUNERAL DIRECTOR <b>Massachusetts Funeral Home</b>	ADDRESS <b>4013 Belair Rd Md</b>

763 377

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 16 1961

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1253

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>200 Bloomsbury Avenue</u>		STREET ADDRESS (If rural, give location) <u>200 Bloomsbury Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>BEULAH</u>	(Middle) <u>CHRISTINA</u>	(Last) <u>BROSENNE</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/21/1887</u>
9. AGE last birthday <u>63</u> yrs.		4. DATE OF DEATH <u>Feb. 21st., 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Anthony Stromberg</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Flanagan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Henry J. Brosenne Catonsville, Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary Edema</u>	<u>1 day</u>
Antecedent cause(s) (b) <u>General Cardiovascular</u>	<u>6 Mos</u>
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

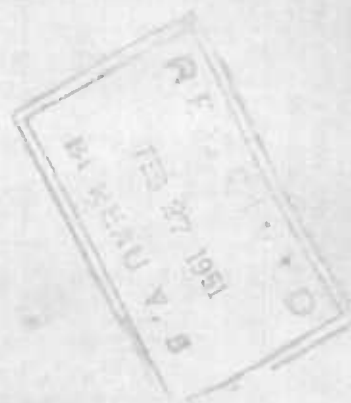
22. I hereby certify that I attended the deceased from <u>5/8</u> , 19 <u>50</u> , to <u>2/22</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>2/16</u> , 19 <u>51</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.	
SIGNATURE <u>James H. Katzenberg M.D.</u>	DATE SIGNED <u>2/23/51</u>
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>2/26/51</u>
NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>2/25/51</u>	24. FUNERAL DIRECTOR <u>Easton Sons</u>
REGISTRAR'S SIGNATURE <u>V E Harry</u>	ADDRESS <u>Catonsville, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH - CITY <u>Baltimore</u> STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>1913 W. North Avenue</u>	
3. NAME OF DECEASED (First) <u>ANITA</u> (Middle) <u>TRENT</u> (Last) <u>BROWN</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>16</u> (Year) <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan. 6, 1926</u>
9. AGE last birthday <u>25</u> yrs.		10. If under 1 year: Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Business Machine</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Albert Trent</u>		14. MOTHER'S MAIDEN NAME <u>Helen B. Wimbrough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records, Catonsville 28, Md.</u>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

586x Immediate cause (a) Respiratory failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

121

(b)

CARDIAC FAILUREAtelectatic areas in lung

(c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION 1-17-51 19b. MAJOR FINDINGS OF OPERATION Cholecystectomy & appendectomy

## 20. AUTOPSY?

Yes ☐ No ☒21. INTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office, etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

DATE SIGNED

## 23. BURIAL, CREMATION OR REMOVAL OF REMAINS

DATE THEREOF 2/20/51NAME OF CEMETERY OR CREMATORY Balto

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 2/19/51REGISTRAR'S SIGNATURE G W Bedwick24. FUNERAL DIRECTOR Wm Cook, Inc. 1217 St. Paul St.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 23</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1218 W. Lexington Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u>	(Middle) <u>(NMI)</u>	(Last) <u>BURKE</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	4. DATE OF DEATH (Month) <u>February</u> (Day) <u>16</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical Plant</u>	5. DATE OF BIRTH <u>7-4-86</u>	9. AGE last birthday <u>64</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>Isaac Burke</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>	16. SOCIAL SECURITY No. <u>Unknown</u>	17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.3 Immediate cause	(a) <u>Encephalomalacia and cerebral hemorrhages</u>	INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
95c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arteriosclerosis of cerebral vessels</u> <u>Cardiac hypertrophy &amp; Dilatation</u>	<u>unknown</u> <u>unknown</u>
	(c)	

#### II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 14, 1951, to Feb. 16, 1951, that I saw the deceased

George Lerner and that death occurred at 2:50 P.m., from the causes and on the date stated above.  
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

GEORGE LERNER, M.D. VAH FORT HOWARD, MD. 2-17-51  
23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)  
Burial Feb 21, 1951 Baltimore National 5501 Frederick Ave. Balto. Md.

DATE REC'D BY LOCAL REG. 2/20/51 REGISTRAR'S SIGNATURE A. W. Hedrick 24. FUNERAL DIRECTOR ADDRESS  
Mrs. Katie R. Williams, 322 N. Schroeder St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1256

1. PLACE OF DEATH: COUNTY <b>Catonsville</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Catonsville</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>833 Braeside Avenue</b>		STREET ADDRESS (If rural, give location) <b>833 Braeside Avenue</b>	
3. NAME OF DECEASED (First) <b>Mary</b> (Middle) <b>Josephine</b> (Last) <b>Cimorelli</b>		4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>21st</b> (Year) <b>1951</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAY 21-1894</b>
9. AGE last birthday <b>56</b> yrs.		10. If under 1 year: Months <b>5</b> Days <b>21</b> Hours <b>12</b> Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEWING WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FLA</b>	
11. BIRTHPLACE (State or foreign country) <b>FLA</b>		12. CITIZEN OF WHAT COUNTRY? <b>ANN</b>	
13. FATHER'S NAME <b>Clement Romeo</b>		14. MOTHER'S MAIDEN NAME <b>ANN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>099-09-2241</b>	
17. INFORMANT AND ADDRESS <b>ALBERT J. Cimorelli, 833 Braeside</b>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <b>Rheumatic Heart Disease</b>		<b>about 45 yrs</b>	
(b) <b>Immediate cause</b>			
(c) <b>Antecedent cause(s)</b>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, office bldg., etc.) <b>INJURY</b>	
TIME (Month) (Day) (Year) (Hour) <b>OF INJURY</b>		INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May</b> , 1950, to <b>Feb 21</b> , 1951, that I last saw the deceased alive on <b>Feb 21</b> , 1951, and that death occurred at <b>12:00 N.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Dr. J. J. Mallow</b>		ADDRESS <b>Baltimore, Md</b>	
DATE SIGNED <b>2/21/51</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		DATE THEREOF <b>2/24/51</b>	
NAME OF CEMETERY OR CREMATORY <b>Brooklyn N.Y.</b>		LOCATION (City, town, or county) <b>Brooklyn N.Y.</b>	
24. FUNERAL DIRECTOR <b>Donald J. Ruck</b>		ADDRESS <b>5305 Harford</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

NT

690 VVV Pd

Dr. Gaver  
1 Mallow Hill Rd

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1257

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u> TOWN <u>Riderwood</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sherwood Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u> TOWN <u>Riderwood</u> STREET ADDRESS (If rural give location) <u>Sherwood Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Ward Baldwin Coe</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 23 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 2, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer, retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Bluffton, S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Theodore Coe</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Kirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Ward B. Coe, Jr. - Burnside Farm, Eccleston, Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH Approximate
332x Immediate cause (a) <u>Cerebral thrombosis</u> Generalized arteriosclerosis	ly 1 wk.
46x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Cerebral Arteriosclerosis</u> Atrophy, with ataxia, of cerebella	Years Years 8 mo.
(c) <u>General debility (Age 72) Carcinoma sigmoid with hepatic metastases, operated upon Dec. '40.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 19, 1950, to Feb. 23, 1951, that I last saw the deceased alive on Feb. 23, 1951, and that death occurred at 11 P.m., from the causes and on the date stated above.

SIGNATURE <u>Benjamin W. ...</u>	ADDRESS <u>18 E. Eager St., Balto. 2, Md.</u>	DATE SIGNED <u>Feb. 24, '51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>2 - 26 - 51</u>	NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>
LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	24. FUNERAL DIRECTOR <u>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Place</u>	ADDRESS <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>February 24/1951</u>	REGISTRAR'S SIGNATURE <u>R. W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

055879



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1258 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armacoost Nursing Home</u> <u>812 Regester Avenue</u>		STREET ADDRESS <u>812 Regester Avenue</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>William</u> (Middle) <u>Joseph</u> (Last) <u>Condon</u>		(Month) <u>Feb.</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12/23/73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Pilots Asso.</u>	9. AGE last birthday <u>77</u> yrs.
13. FATHER'S NAME <u>Garrett Condon</u>		11. BIRTHPLACE (State or foreign country) <u>Texas, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Nora J. Brown 1610 Mt. Royal Avenue</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Carcinoma, primary site unknown</u>				<u>Unknown</u>	
Antecedent cause(s) (b) <u>Carcinoma, left Hip joint, metastatic</u>				<u>6 months</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 8</u> , 19 <u>50</u> , to <u>Feb 20</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Feb. 20</u> , 19 <u>51</u> , and that death occurred at <u>4:35 P.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Joseph H. Bird, M.D.</u>		ADDRESS <u>1532 Haverwood Rd</u>		DATE SIGNED <u>Feb 22, 1951</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE <u>2/24/51</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR		ADDRESS <u>26 W. Meade Ave. Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/23/51</u>		REGISTRAR'S SIGNATURE <u>G. W. Bedecarr</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

390546

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1250 30

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rev. A. Opitz Home</b>		STREET ADDRESS (If rural, give location) <b>3204 Ellamont Rd.</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>George</b>	(Middle)	(Last) <b>Corkinides</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH <b>March 10 1866</b>
10a. USUAL OCCUPATION (Give kind of work done during present working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE last birthday <b>84</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Turkey</b>		12. CITIZEN OF WHAT <b>Turkey</b>	
13. FATHER'S NAME <b>Constandine Corkinides</b>		14. MOTHER'S MAIDEN NAME <b>Athena Corkinides</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY No. <b>NONE</b>	
17. INFORMANT <b>C.G. Paris</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <b>MYOCARDIAL DEGENERATION. CHRONIC</b>		<b>6 Mo</b>
(b) <b>SENILITY</b>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Nov 20, 1950**, to **Feb 11, 1951**, that I last saw the deceased alive on **Feb 8, 1951**, and that death occurred at **11:42** a.m., from the causes and on the date stated above.

SIGNATURE <b>D. Lloyd Johnson M.D.</b>		(Degree or title)		ADDRESS <b>Catonsville, Md.</b>		DATE SIGNED <b>2/13/51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>2/15/51</b>		NAME OF CEMETERY OR CREMATORY <b>Fredericksburg Cem.</b>		LOCATION (City, town, or county) (State) <b>Fredericksburg, Va.</b>	
DATE REC'D BY LOCAL REG. <b>2-13-51</b>		REGISTRAR'S SIGNATURE <b>V.E. Harry</b>		24. FUNERAL DIRECTOR <b>George S. Agnew Funeral Home Inc.</b>		ADDRESS <b>1118 W. 4th Royal Ave.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. S. L. Johnson  
610 Fredrick Rd.

Tues - 9-10 AM



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1260

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wiltondale-Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wiltondale-Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>626 Yarmouth Rd</u>		STREET ADDRESS (If rural give location) <u>626 Yarmouth Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert</u> (Middle) <u>Alphonso</u> (Last) <u>Grandall</u>	4. DATE OF DEATH	(Month) <u>Feb</u> (Day) <u>15</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/27/1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Builder</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>A. A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm N. Grandall</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>626</u>	
17. INFORMANT <u>Howard L. Grandall</u>		<u>626 Yarmouth Rd</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Heart disease, coronary with occlusion</u>		<u>Sudden</u>
Antecedent cause(s) (b) <u>Hypertension</u>		<u>Unknown</u>
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>		<u>Unknown</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Rollin L. Hudson M.D.</u>	DATE SIGNED <u>2/15/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/19/51</u>
NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>	LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 17, 1951</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>
24. FUNERAL DIRECTOR <u>W. C. Cook Inc</u>	ADDRESS <u>1217 St. Paul St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1261

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bradshar, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>523 Riverside Dr.</u>		STREET ADDRESS (If rural, give location) <u>R. 7. D.</u>	
3. NAME OF DECEASED (Type or Print) <u>Richard</u> (First) <u>O</u> (Middle) <u>Dailey</u> (Last)		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>14</u> (Year) <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 4 - 1866</u>
9. AGE last birthday <u>84</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm. Dailey</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Frederick Dailey, 523 Riverside Dr.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause

Antecedent cause(s)  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Coronary occlusions.

(b) Cardiovascular Disease.

(c) ?

INTERVAL BETWEEN ONSET AND DEATH  
1/2 hr.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>2/16/51</u>	<u>Elmwood Cem.</u>	<u>Shpherdstown - W. Va.</u>	<u>W. Va.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/15/51</u>	<u>A.W. Hedlund</u>	<u>John J. Connelly</u>	<u>418 Eastern Ave.</u>	

043246 Balto. 21-md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Rural - Parkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Rural near Millers</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Upper Hoffmanville Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Vernon</u> (Middle) <u>Kenneth</u> (Last) <u>Damewood</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Mar. 2, 1889</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		9b. AGE last birthday <u>61</u> yrs.	
10. FATHER'S NAME <u>Andrew J. Damewood</u>		11. BIRTHPLACE (State or foreign country) <u>Newcastle, Va.</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		13. SOCIAL SECURITY NO. <u>217-22-0408</u>	
14. FATHER'S NAME <u>Andrew J. Damewood</u>		15. MOTHER'S MAIDEN NAME <u>Florence Caldwell</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT AND ADDRESS <u>Mrs. Charles Rother, Relay, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) <u>Immediate cause</u> <u>420.1</u> <u>Coronary Occlusion</u>			
(b) <u>Antecedent cause(s)</u> <u>94a</u> <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u>Other significant conditions</u> Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Lead on arrival</u> , 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>11:00 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>A. M. France</u>		ADDRESS <u>M.D. Parkton Md.</u>	
DATE SIGNED <u>2/20/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Febr. 26, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>		LOCATION (City, town, or county) (State) <u>St. Paul, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/27/51</u>		REGISTERAR'S SIGNATURE <u>Charles L. Frazier</u>	
24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

763499



RECEIVED  
MAR 5 1951  
BUREAU V. S.

29155

Former Address 1839 N. Caroline St.  
**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles Street, Baltimore

**CERTIFICATE OF DEATH**

Reg. Dist. No. 1267

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balta</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Augsburg Home</u>		STREET ADDRESS (If rural give location) <u>Campfield Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mamie F. Doenges</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 2 19 51</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/6/1881</u>
9. AGE last birthday <u>70</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Records Augsburg Home</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>420.1</u>		<u>Coronary Thrombosis</u>		<u>2 days.</u>	
Antecedent cause(s) <u>74a</u>		<u>Dist. Solensia &amp; coronary Solensia</u>		<u>1 yr.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		<u>Hypertension</u>		<u>3 1/2 yrs.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July, 1946, to Feb. 27, 1951, that I last saw the deceased alive on Feb. 2, 1951, and that death occurred at 5:45 P. m., from the causes and on the date stated above.

SIGNATURE <u>Jane S. Miller</u>		ADDRESS <u>Pikesville, Md.</u>		DATE SIGNED <u>2/4/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE <u>Feb. 5 51</u>		NAME OF CEMETERY OR CREMATORY <u>Immanuel</u>	
LOCATION (City, town, or county) (State)		<u>Baltimore Md.</u>			
DATE REC'D BY LOCAL REG. <u>2/5/51</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		24. FUNERAL DIRECTOR ADDRESS <u>Paul A. Heemann 6067 Harford Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1590	1590
1581	1581
1571	1571
1561	1561
1551	1551
1541	1541
1531	1531
1521	1521
1511	1511
1501	1501
1491	1491
1481	1481
1471	1471
1461	1461
1451	1451
1441	1441
1431	1431
1421	1421
1411	1411
1401	1401
1391	1391
1381	1381
1371	1371
1361	1361
1351	1351
1341	1341
1331	1331
1321	1321
1311	1311
1301	1301
1291	1291
1281	1281
1271	1271
1261	1261
1251	1251
1241	1241
1231	1231
1221	1221
1211	1211
1201	1201
1191	1191
1181	1181
1171	1171
1161	1161
1151	1151
1141	1141
1131	1131
1121	1121
1111	1111
1101	1101
1091	1091
1081	1081
1071	1071
1061	1061
1051	1051
1041	1041
1031	1031
1021	1021
1011	1011
1001	1001
991	991
981	981
971	971
961	961
951	951
941	941
931	931
921	921
911	911
901	901
891	891
881	881
871	871
861	861
851	851
841	841
831	831
821	821
811	811
801	801
791	791
781	781
771	771
761	761
751	751
741	741
731	731
721	721
711	711
701	701
691	691
681	681
671	671
661	661
651	651
641	641
631	631
621	621
611	611
601	601
591	591
581	581
571	571
561	561
551	551
541	541
531	531
521	521
511	511
501	501
491	491
481	481
471	471
461	461
451	451
441	441
431	431
421	421
411	411
401	401
391	391
381	381
371	371
361	361
351	351
341	341
331	331
321	321
311	311
301	301
291	291
281	281
271	271
261	261
251	251
241	241
231	231
221	221
211	211
201	201
191	191
181	181
171	171
161	161
151	151
141	141
131	131
121	121
111	111
101	101
91	91
81	81
71	71
61	61
51	51
41	41
31	31
21	21
11	11
1	1

# MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

1230  
Reg. Dist. No. ....

<b>1. PLACE OF DEATH - COUNTY</b> <i>Baltimore</i> MARYLAND		<b>2. USUAL RESIDENCE (HOME) OF DECEASED - STATE</b> <i>Pa</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Riversdale</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>516 Elm Street, Catonsville, Md</i>		STREET ADDRESS (If rural, give location) <i>2007 Oxford Rd</i>	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Vera</i> (First) <i>Eastbourne</i> (Middle) <i>Eastbourne</i> (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>July 2 1957</i>	
<b>5. SEX</b> <i>7</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>W</i>	<b>8. DATE OF BIRTH</b> <i>Dec-26-1873</i>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Reg. Nurse</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Germany</i>	
<b>13. FATHER'S NAME</b> <i>George E. Carstens</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Doretta Unknown</i>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>Snelling Fun'l Home. Portsmouth Va.</i>	

#### 18. MEDICAL CERTIFICATION

##### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

###### Immediate cause

(a)

*Acute Cardiac failure*

###### Antecedent cause(s)

(b)

*Bandaged vascular disease*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

*Serility*

##### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

##### 19a. DATE OF OPERATION

##### 19b. MAJOR FINDINGS OF OPERATION

##### 20. AUTOPSY?

Yes ☐ No ☒

##### 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

##### PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

##### (CITY OR TOWN)

##### (COUNTY)

##### (STATE)

##### TIME (Month) (Day) (Year) (Hour) OF INJURY

##### INJURY OCCURRED While at work ☐ Not while at work ☐

##### HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

##### SIGNATURE

(Degree or title)

##### ADDRESS

##### DATE SIGNED

##### 23. BURIAL, CREMATION REMOVAL (Specify)

##### DATE THEREOF

##### NAME OF CEMETERY OR CREMATORY

##### LOCATION (City, town, or county)

##### (State)

##### DATE REC'D BY LOCAL REG.

##### REGISTRAR'S SIGNATURE

##### 24. FUNERAL DIRECTOR

##### ADDRESS

*July 3, 1957*

*RW*

*Wm Cook Inc. 1217 St Paul St*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

781000

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore - Westport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>2820 Maisel Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Blanche</u> (Middle) <u>Ellen</u> (Last) <u>Ebert</u>	4. DATE OF DEATH	(Month) <u>Feb</u> (Day) <u>17</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, <u>WIDOWED</u> DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug 24, 1875</u>
9. AGE last birthday <u>75</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City School System</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>William Radakein</u>	14. MOTHER'S MAIDEN NAME <u>Rosalie Smiley</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Hospital records - Spring Grove State Hospital</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Acute Myocardial Failure

INTERVAL BETWEEN ONSET AND DEATH

12 hours

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Hypertensive and arteriosclerotic cardiovascular disease

6 yrs

(c) Diabetes Mellitus

6 yrs

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Psychosis with cerebral arteriosclerosis

6 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 17, 1945, to Feb. 17, 1951, that I last saw the deceased alive on Feb. 17, 1951, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Arnold H. Eichert, M.D.

Spring Grove State Hosp. Catonsville

2-17-51

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/20/51</u>	<u>Mt. Olivet</u>	<u>Balto. Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2/19/51</u>	<u>G. W. Hedrick</u>	<u>Wm. Cook Inc. 1217 St. Paul St.</u>	

754-888

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1266 *42*

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Relay</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>9 days</u> Hospital, institution, or street address where death occurred: <u>Relay Sanatorium</u> How long in hospital or institution? <u>9 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>5203 Falls Rd</u> (If rural, give LOCATION) 2.(a) If veteran, name war <input checked="" type="checkbox"/>			
<b>3. (a) FULL NAME</b> <u>William Voss Elder</u>				<b>3. (b) Social Security Number</b> <u>←</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Nina Poe Elder</u>							
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>October 29, 1870</u>							
<b>8. AGE:</b> Years <u>80</u> Months <u>4</u> Days <u>5</u> If less than one day _____ hrs. _____ min.							
<b>9. Birthplace</b> <u>Baltimore, Md.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Retired Executive</u>							
<b>11. Industry or business</b> <u>Wholesale Groceries &amp; Sausages</u>							
<b>12. Name</b> <u>Robert North Elder</u>							
<b>13. Birthplace</b> <u>Baltimore, Md.</u>							
<b>14. Maiden name</b> <u>Susan Voss</u>							
<b>15. Birthplace</b> <u>Baltimore, Md.</u>							
<b>16. Informant</b> <u>Mrs. S. E. Symington</u> Address <u>5203 Falls Rd., Baltimore, Md.</u>							
<b>17. (Burial, cremation, or removal. Which?)</b> <u>Burial</u> Date thereof <u>Feb 27 1951</u> (month) (day) (year) Cemetery or crematory <u>St. Johns</u> Location <u>Northampton Valley</u>							
<b>18. Funeral director</b> <u>Henry M. Siskins, Inc.</u> Address <u>4905 York Rd</u> <u>51 Pa. Hedrock</u>							
<b>19. (Date rec'd by registrar)</b> <u>2/26/51</u> Registrar <u>Day</u>							
<b>MEDICAL CERTIFICATION</b>							
<b>20. DATE OF DEATH</b> <u>February 25<sup>th</sup></u> 19 <u>51</u> , at <u>12:15 AM</u>							
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>February 16<sup>th</sup></u> 19 <u>51</u> , to <u>Feb 25<sup>th</sup></u> 19 <u>51</u> and that I last saw him alive on <u>February 24<sup>th</sup></u> 19 <u>51</u>							
<b>Immediate cause of death</b> <u>Cerebral Thrombosis</u>				<b>DURATION</b> <u>3 days</u>			
<b>Due to</b> <u>Cerebral Arteriosclerosis several years</u>				<b>Due to</b> <u>Generalized Arteriosclerosis several years</u>			
<b>Other conditions</b> <u>332A</u> <u>83b</u> (Include pregnancy within 3 months of death)							
<b>Major findings of operations</b> Date of op. _____							
<b>Autopsy results</b> <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____							
<b>23. SIGNATURE</b> <u>Erin P. Tumbly M.D.</u> Address <u>Relay Sanatorium, Relay, Md.</u> Date signed <u>2/25/51</u> <u>2290625</u>							



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 126 W. Ostend Street	
3. NAME OF DECEASED (First) FRANKLIN (Middle) PEARCE (Last) EREY		4. DATE OF DEATH (Month) February (Day) 6 (Year) 51	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 4-24-95
9. AGE last birthday 55 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Erey		14. MOTHER'S MAIDEN NAME Mary Larrimore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. 214-03-5068	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) BILATERAL CARCINOMA OF ADRENALS			UNKNOWN
Antecedent cause(s) (b) None			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 27, 1950, to Feb. 6, 1951, that I last saw the deceased on Feb. 6, 1951, and that death occurred at 9:55 P.m., from the causes and on the date stated above.			
SIGNATURE Paul Padget		ADDRESS	
PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND		DATE SIGNED 2-7-51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Feb. 10, 1951	
NAME OF CEMETERY OR CREMATORY Holy Cross		LOCATION (City, town, or county) A. G. Co. (State) Ind	
24. FUNERAL DIRECTOR		ADDRESS	
Curtis E. Evans		1400 S. Charles Street	
Baltimore, Maryland			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1268 30

1. PLACE OF DEATH COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville 28</u> LENGTH OF STAY <u>9 yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>728 Edmonson Ave.</u>		STREET ADDRESS (If rural, give location) <u>728 Edmonson Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>GERTRUDE ANETTA EVERLY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2/16/51</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/8/1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE last birthday <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Stotelmayer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ball</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>George W. Everly</u>	
17. INFORMANT AND ADDRESS <u>George W. Everly</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Myocardial dilatation &amp; failure</u>	<u>12 hours</u>
Antecedent cause(s) (b) <u>Atherosclerotic cardiovascular disease</u>	<u>Unknown</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 27, 1951, to Feb 16, 1951, that I last saw the deceased alive on Feb 16, 1951, and that death occurred at 11:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2/19/51</u>	<u>Good Shepherd</u>	<u>Catonsville</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	2. FUNERAL DIRECTOR	ADDRESS	
<u>2/18/51</u>	<u>V E. Harry</u>	<u>MacGibbon &amp; Son</u>	<u>Catonsville</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1269

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1816 Kinship Road</u>		STREET ADDRESS (If rural, give location) <u>1816 Kinship Road</u>	
3. NAME OF DECEASED (First) <u>EDNA</u> (Middle) <u>MURL</u> (Last) <u>FAHEY</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>17</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 16, 1913</u>
9. AGE last birthday <u>37</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George F. Spence</u>		14. MOTHER'S MAIDEN NAME <u>Ida O. Townsend</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>22</u>	
17. INFORMANT <u>Leroy J. Fahey</u>		<u>1816 Kinship Road</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Embolus</u>				<u>1 hr</u>	
Antecedent cause(s) (b) <u>arterio Sclerosis</u>				<u>6 mo</u>	
Diseases or conditions, if any, giving rise to the above cause last stating the underlying cause last (c) <u>Hodgkins Disease</u>		<u>Repts sent) Ext</u>		<u>29th 5 mo</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>Jul 5 48</u>		19b. MAJOR FINDINGS OF OPERATION <u>Hodgkins Disease &amp; embolus</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>		(CITY OR TOWN) <u>Baltimore</u> (COUNTY) <u>Baltimore</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>None</u>	
22. I hereby certify that I attended the deceased from <u>Oct 17, 1948</u> , to <u>Feb 17, 1951</u> , that I last saw the deceased alive on <u>Feb 17, 1951</u> , and that death occurred at <u>5:30 P</u> m., from the causes and on the date stated above.					
SIGNATURE <u>J. S. A. Stevens MD</u>		ADDRESS <u>2818 Harford Rd</u>		DATE SIGNED <u>Feb 21 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Feb. 21, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>2/21/51</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u> ADDRESS <u>2008 Orleans St.,</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1270  
Reg. Dist. No. 42

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Cecil COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Relay		CITY (If outside corporate limits, write RURAL and give nearest town) Perryville, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Relay Sanitarium Relay, Md.		STREET ADDRESS none (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) William (Middle) Leroy (Last) Fisher		4. DATE OF DEATH (Month) Feb. (Day) 27 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Jan. 12, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none at present		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 49- yrs. If under 1 year 12 Months. If under 24 hrs. Days Hours Min.
11. BIRTHPLACE (State or foreign country) Cecil Co., Perryville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME B Walter Fisher		14. MOTHER'S MAIDEN NAME Ella V. Thorpy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Brother: Walter Fisher, Perryville, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Barbiturate poisoning		4 days
Antecedent cause(s) (b) Bronchial asthma		several years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) (no suicidal intent)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-24-51., 19....., to 2-27....., 1951., that I last saw the deceased alive on 2-27....., 1951., and that death occurred at 10:30 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3-2-1951	NAME OF CEMETERY OR CREMATORY North East, M.E.	LOCATION (City, town, or county) North East, Md.	(State)
DATE REC'D BY LOCAL REG. Feb. 28, 1951	REGISTRAR'S SIGNATURE E. S. M. Kieffer	24. FUNERAL DIRECTOR W. A. Patterson & Son	ADDRESS Perryville, Md.	

DATE *Mar 5 1952*

*C. F. G.*

COPY SENT TO *188*



Evidence for addition  
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1271

CERTIFICATE OF DEATH

Reg. Dist. No. 30

FILM No. G 13 FEB 14 1951

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> <u>Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO CITY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
TOWN <u>CATONSVILLE</u>		TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hosp.</u>		STREET ADDRESS (If rural, give location) <u>WYMAN PARK APTS</u>	
3. NAME OF DECEASED (First) <u>CLARA</u> (Middle) <u>WILSON</u> (Last) <u>FOREMAN</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Oct 1860</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chaperone in girls home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Hosp. Records</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cardio respiratory failure</u>		
Antecedent cause(s) (b) <u>senility</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None (2/13/51 aka)</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-8, 1950, to 2-2, 1951, that I last saw the deceased alive on 2-2, 1951, and that death occurred at 7:05 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> DATE <u>Feb 3/51</u>		NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u>		LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>2-3-51</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>John O Mitchell</u> ADDRESS <u>1901 Eastern Ave.</u>	

764 897

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1272

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Co - Charles</b>	
TOWN <b>Fort Howard</b>		TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vet. Adm. Hosp., Ft. Howard, Md.</b>		STREET ADDRESS (If rural, give location) <b>919 Francis Avenue</b>	
3. NAME OF DECEASED (Type or Print) <b>JUSTIN</b> (First) <b>D.</b> (Middle) <b>FOUNTAIN</b> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <b>February 26</b> <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>4-28-82</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman &amp; Collector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Co.</b>	9. AGE last birthday <b>68</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Fountain</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth (NM - Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY No. <b>Unknown</b>	
17. INFORMANT AND ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <b>331x</b>	(a) <b>LOBULAR PNEUMONIA LEFT LOWER AND RIGHT LOWER LOBES</b>	<b>3 days</b>
Antecedent cause(s) <b>108</b>	(b) <b>CEREBRAL HEMORRHAGES, MULTIPLE, OLD</b>	<b>Unknown</b>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<b>CARDIAC HYPERTROPHY AND DILATATION</b>	<b>6 years +</b>
---	---	------------------

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb. 25, 1951**, to **Feb. 26, 1951**, that I last saw the deceased

**any on** and that death occurred at **9:25 A.M.**, from the causes and on the date stated above.

SIGNATURE **H. C. MANAUGH** (Degree or title) ADDRESS **2-26-51** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Mar-1-51</b>	NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
DATE RECD BY LOCAL REG. <b>3/1/51</b>	REGISTRAR'S SIGNATURE <b>Rev. Hedrick</b>	24. FUNERAL DIRECTOR <b>Fred B. Wippert &amp; Son</b>	ADDRESS <b>Baltimore &amp; Monroe 434736 Baltimore, Maryland</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH COUNTY <u>PARKTON</u> <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> <u>WASHINGTON</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>541 W. Church St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MOLLIE</u> <u>Adela</u> <u>FRANCE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb</u> <u>28</u> <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MAY 13, 1872</u>
9. AGE last birthday <u>78</u> yrs.		10. If under 1 year Months <u>11</u> Days <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sewer worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>sewer worker</u>	
11. BIRTHPLACE (State or foreign country) <u>CHAMBERSBURG, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MENARD HUMELSHINE</u>		14. MOTHER'S MAIDEN NAME <u>MARY SIMMERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>A. M. FRANCE, PARKTON, MD</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardio-vascular-renal disease

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 30 Jan, 1951, to 28 Feb, 1951, that I last saw the deceased alive on 27 Feb, 1951, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

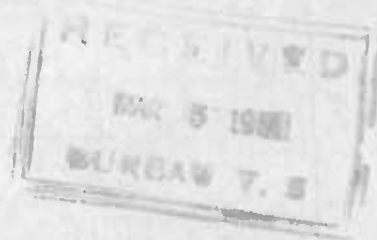
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1274

Reg. Dist. No. 32

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
TOWN <u>Pikesville</u>		TOWN <u>Pikesville</u>	
HOSPITAL (OR) INSTITUTION OR STREET ADDRESS <u>11 Brightside Ave</u>		STREET ADDRESS (If rural give location) <u>11 Brightside Ave</u>	
3. NAME OF DECEASED (First) <u>Charles</u> (Middle) <u>Garrish</u> (Last) <u>Garrish</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>11/14/1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Garrish</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Uhler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>212-10-2962</u>	
17. INFORMANT <u>Mrs. Frank Broaders</u>		<u>11 Brightside Ave Pikesville Md</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
331x Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>3 wks.</u>
83a Antecedent cause(s) (b) <u>Hypertension -</u>			<u>2 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Art. Sclerosis</u>			<u>10 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from P.O......, 1949....., to Feb 22....., 1951....., that I last saw the deceased alive on Feb 22....., 1951....., and that death occurred at 6:40 P......m., from the causes and on the date stated above.

SIGNATURE <u>James A. Miller M.D.</u>	(Degree or title)	ADDRESS <u>Pikesville - P. Md</u>	DATE SIGNED <u>2/22/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE <u>2-26-51</u>	NAME OF CEMETERY OR CREMATORY <u>Green Ridge</u>	LOCATION (City, town, or county) <u>Pikesville Md</u> (State)
DATE REC'D BY LOCAL REG. <u>Feb 24-51</u>	REGISTRAR'S SIGNATURE <u>W. B. B. Michael</u>	24. FUNERAL DIRECTOR <u>Frank A. Quirell</u>	ADDRESS <u>Pikesville Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1275

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Dundalk</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dundalk</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>103 Thise Ave.</u>		STREET ADDRESS (If rural, give location) <u>1120 E. 30th Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary E. Steckle</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 8 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 24-1876</u>
9. AGE last birthday <u>74 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md</u>	
13. FATHER'S NAME <u>Dominic Eberle</u>		14. MOTHER'S MAIDEN NAME <u>Ella Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>1120 E 30th</u>	
17. INFORMANT AND ADDRESS <u>Mrs Francis Trail</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH 2 days

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized arteriosclerosis

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

##### 19a. DATE OF OPERATION

##### 19b. MAJOR FINDINGS OF OPERATION

##### 20. AUTOPSY?

Yes ☐ No ☒

##### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-6, 1951, to 2-8, 1951, that I last saw the deceased

alive on 2-8, 1951, and that death occurred at 10:15 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

##### 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF Feb 12/51

NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery

LOCATION (City, town, or county) Baltimore Md

(State)

DATE REC'D BY LOCAL REG. 2/12/51

REGISTRAR'S SIGNATURE [Signature]

24. FUNERAL DIRECTOR [Signature]

ADDRESS 5305 Bayford Rd

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonville</b>	
TOWN <b>21 Yrs.</b>		TOWN <b>Catonville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1800 Edmonson Ave.</b>		STREET ADDRESS (If rural, give location) <b>23 N. Rolling Rd.</b>	
3. NAME OF DECEASED (Type or Print) <b>Eva B. Gibbons</b>		4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>26,</b> (Year) <b>1951</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 11, 1887</b>
9. AGE last birthday <b>63</b> yrs.		10. If under 1 year Months <b>1</b> Days <b>24</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore City</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Wicklein</b>		14. MOTHER'S MAIDEN NAME <b>Sue Elizabeth Wicklein</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT <b>Betty McManey-1800 Edmonson Ave.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>Coronary Embolism</b>		<b>1 1/2 hours</b>
Antecedent cause(s) (b) <b>Arteriosclerotic Cardio-Vascular Dis.</b>		<b>8 yrs.</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

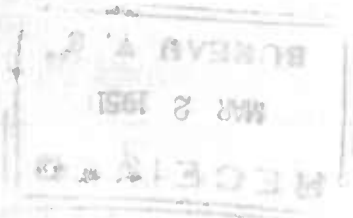
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <b>4.18</b> , 19 <b>48</b> to <b>2.26</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>2.25</b> , 19 <b>51</b> , and that death occurred at <b>9:50 P</b> m., from the causes and on the date stated above.		DATE SIGNED <b>2-26-51</b>
SIGNATURE <b>George E. Elston</b>	(Degree or title) <b>M.D.</b>	ADDRESS <b>805 E. D. Ave. Baltimore Md</b>
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>March 1, 51</b>	NAME OF CEMETERY OR CREMATORY <b>St. John Long Green</b>
LOCATION (City, town, or county) <b>Baltimore Co., Maryland</b>	(State)	
DATE REC'D BY LOCAL REG. <b>2/28/51</b>	REGISTRAR'S SIGNATURE <b>V.E. Harry</b>	24. FUNERAL DIRECTOR <b>Chas F. Evans &amp; Son Inc</b>
		ADDRESS <b>118 W. Mt. Royal Ave</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

805 Toland Rd



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1277

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hosp.</u>		STREET ADDRESS (If rural, give location) <u>502 Oakland Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>SAMUEL E. GIBSON</u>		4. DATE OF DEATH <u>February 23</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/3/90</u>
9. AGE last birthday <u>60</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel H. Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Hopkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Clin. Records, Vet. Adm. Hosp., Ft. Howard, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) MYOCARDIAL INFARCTION

INTERVAL BETWEEN ONSET AND DEATH

Recent

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ARTERIOSCLEROTIC HEART DISEASE

Unknown

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 19, 1951, to Feb. 23, 1951, and that death occurred at 3:25 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

PAUL PADGET, M.D., CHIEF, MEDICAL SERVICE, VET. ADM. HOSP., FORT HOWARD, MD. 2/23/51

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>2-27-1951</u>		<u>U.S. National</u>		<u>Baltimore</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>2/26/51</u>		<u>[Signature]</u>		<u>John Q. Moran</u>		<u>Moran Funeral Home, Greenmount &amp; 42 Sts. Balto. Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Co.</u>	
TOWN <u>Catonville</u>		TOWN <u>Balto. Co.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3514 Rolling Rd.</u>		STREET ADDRESS (If rural, give location) <u>3510 Rolling Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>FANNIE</u>	(Middle) <u>COHN</u>	(Last) <u>GOSNELL</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 23, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>79</u> yrs. <input type="checkbox"/> If under 1 year <input type="checkbox"/> 1 year <input type="checkbox"/> 1 year <input type="checkbox"/> 1 year <input type="checkbox"/> 1 year
11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Verney</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gosnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Miss Eliz. K. Gosnell - 3514 Rolling Rd.</u>		18. MOTHER'S MAIDEN NAME <u>Balto. 7, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Arteriosclerosis cardiac vascular</u>					
Antecedent cause(s) (b) <u>Disease + similar</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>hypertension</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/16</u> , 19 <u>50</u> , to <u>2/18</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>2/18/51</u> , 19 <u>51</u> , and that death occurred at <u>3:30</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Wm. J. Pickner &amp; Sons</u>		ADDRESS <u>3033 W. North St.</u>		DATE SIGNED <u>2/15/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE <u>2/20/51</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>	
LOCATION (City, town, or county) <u>Balto., Md.</u>		(State) <u>Md.</u>		24. FUNERAL DIRECTOR <u>Wm. J. Pickner &amp; Sons</u>	
DATE REC'D BY LOCAL REG. <u>2/19/51</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		ADDRESS <u>Balto., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 115

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1279

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 430 Greenlow Rd.		STREET ADDRESS (If rural, give location) 430 Greenlow Rd.	
3. NAME OF DECEASED (Type or Print)	(First) FANNIE (Middle) R. (Last) GRIFFIN	4. DATE OF DEATH (Month) Feb. (Day) 26, (Year) 19 51	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Sept. 20, 1880
9. AGE last birthday 70 yrs.		10. If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Bowen		14. MOTHER'S MAIDEN NAME Laura Shroyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Mrs. Kenneth Albaugh - 430 Greenlow Rd.		Catonsville, Md.	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Coronary Thrombosis

## INTERVAL BETWEEN ONSET AND DEATH

8 hours

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) cardiac Vascular Disease

8 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 24, 1951, to Feb 26, 1951, that I last saw the deceased alive on Feb 26, 1951, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/1/51	NAME OF CEMETERY OR CREMATORY Carroll Chapel	LOCATION (City, town, or county) Balto. Co., Md.	(State)
DATE REC'D BY LOCAL REG. 2/2/51	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No. **45**

1280

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY <b>Balto</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Essex</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Essex</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>111 Margaret Ave</b>		STREET ADDRESS (If rural, give location) <b>111 Margaret Ave.</b>	
3. NAME OF DECEASED (Type or Print) (First) <b>WILLIAM</b> (Middle) <b>D.</b> (Last) <b>HAASE</b>		4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>9</b> (Year) <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>7-11-1876</b>
9. AGE last birthday <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Haase</b>		14. MOTHER'S MAIDEN NAME <b>Anna Hildebrandt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY No. <b>none</b>	
17. INFORMANT AND ADDRESS <b>Mrs. Emma Edwards</b>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <b>Coronary Occlusion</b>	
940.2 Antecedent cause(s) (b) <b>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</b>	
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE **W.B. Davis** (Degree or title) ADDRESS **245 N. Met St. - Dundalk - Md.** DATE SIGNED **2/11/57**

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>2-12-57</b>	<b>Immanuel Ceme.</b>	<b>Balto</b>	<b>Md.</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>February 12, 1957</b>	<b>Edith Curley</b>	<b>John S. Connolly</b>	<b>418 Eastern Ave</b>	
<b>770 W. W. Balto 21. Md</b>				

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED  
FEB 14 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1281 43

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overlea</u> LENGTH OF STAY (in this place) <u>18 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>102 E. Overlea Ave</u>		STREET ADDRESS (If rural, give location) <u>102 E. Overlea Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>Haebler</u> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>16</u> <u>1951</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec 18 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>75</u> yrs. If under 1 year 1 month 1 day If under 24 hrs. Months Days Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony J. Haebler Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Gettermen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Louise Haebler 102 E. Overlea Ave</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Myocardial infarction</u>			<u>1 week</u>
93d Antecedent cause(s) (b) <u>Chronic myocarditis</u>			<u>2 mos</u>
11. OTHER SIGNIFICANT CONDITIONS (c) <u>Arterio-sclerosis</u>			<u>3 yrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, or office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec 13, 1950, to Feb 16, 1951, that I last saw the deceased alive on Feb 13, 1951, and that death occurred at 2 30 m., from the causes and on the date stated above.

SIGNATURE Edmund A. Furman (Degree or title) ADDRESS

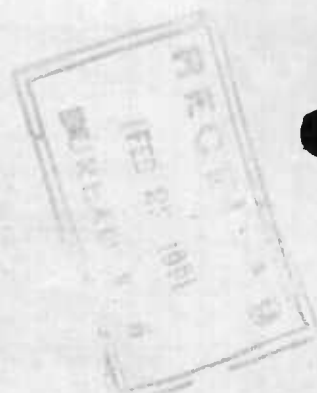
DATE SIGNED 2/17/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb-19-51</u>	<u>Holy Redeemer</u>	<u>4600 Belair Rd.</u>	<u>Balto Md</u>
DATE REG. BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb. 17 '51</u>	<u>Mrs. A. L. Reynolds</u>	<u>Wippel Bros.</u>	<u>7110 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1282

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>37 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>				STREET ADDRESS (If rural, give location) <u>512 E. 28th St.</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u>		(First) <u>J.</u> (Middle) <u>HALLAMEYER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 8 19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>1-11-94</u>	9. AGE last birthday <u>57</u> yrs.	If under 1 year Months   Days   Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical work Casual labor - self-emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Joseph Hallameyer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kohler</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>216-03-5162</u>		17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) BRONCHIAL PNEUMONIA

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 weeks

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic alcoholism5 yearsCirrhosis, Laennec's4 years(c) Peripheral neuritis involving both legs5 years

## II. OTHER SIGNIFICANT CONDITIONS

Chronic nephritisUnknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1951, to Feb. 8, 1951, that I last saw the deceasedon Jan. 12, 1951, and that death occurred at 7:10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ASSISTANT CHIEF, MEDICAL SERVICE, VAH, FT. HOWARD, MD. 2-9-5123. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

February 10, 1951R.W.Little Funeral Home 2700 Edmondson Ave.Baltimore, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970319

Lo. 3470



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05

1283

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>433 Maryland Ave</u>		STREET ADDRESS (If rural, give location) <u>433 Maryland Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u>	(Middle) <u>LEO</u>	(Last) <u>HAMMEN</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 13-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>
13. FATHER'S NAME <u>Geo Hammen</u>		14. MOTHER'S MAIDEN NAME <u>Madeline Hartman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT <u>Mrs. Bertha S. Hayden</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Myocardial infarction, Coronary thrombosis, 1 hr.</u>		
Antecedent cause(s) (b) <u>Coronary Artery disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Ischemic Heart Disease</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u>	(CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>

22. I hereby certify that I attended the deceased from 2/20, 1951, to 2/20, 1951, that I last saw the deceased alive on Nov 19, 1951, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE D. Jay Galt (Degree or title) M.D. ADDRESS 434 Eastern Ave. Balto. 21 DATE SIGNED 2/21/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2-24-51</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	LOCATION (City, town, or county) <u>Balto., Co. Md</u>	(State) <u></u>
DATE REC'D BY LOCAL REG. <u>2/23/51</u>	REGISTRAR'S SIGNATURE <u>E. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>John S. Connelly - 418 Eastern Ave.</u>	ADDRESS <u>564 VVV Balto 21, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1284

Reg. Dist. No. *10*

1. PLACE OF DEATH- COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Sparrow Pt.</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Sparrows Point Hospital</i>				STREET ADDRESS (If rural, give location) <i>3037 Chesterfield Ave</i>	
3. NAME OF DECEASED (Type or Print)		(First) <i>Gilman</i>		(Last) <i>Head (Headed)</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		4. DATE OF DEATH (Month) <i>2</i> (Day) <i>8</i> (Year) <i>1951</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Dec. 19, 1900</i>		9. AGE last birthday <i>50</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Millwright</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel Co.</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Robert Lee Head</i>		14. MOTHER'S MAIDEN NAME <i>Effie Cheschrie</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY No. (If yes, give war or dates of service) <i>World #1 213-07-0636</i>		17. INFORMANT <i>Mrs Mary L. Head</i> <i>3037 Chesterfield Ave</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <i>Coronary Occlusion</i>			
420.1 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>94a</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE *J. B. Davis* ADDRESS *Syndes. Saw. Dundas. rr. Md.* DATE SIGNED *2/8/51*

23. BURIAL, CREMATION, or other disposal (Specify) *Burial* DATE THEREOF *2/12/1951* NAME OF CEMETERY OR CREMATORY *Oaklawn* LOCATION (City, town, or county) *Baltimore Md.* (State)

DATE REC'D BY LOCAL REG. *2/9/51* REGISTRAR'S SIGNATURE *A. W. Hedrick* 24. FUNERAL DIRECTOR & Sons Inc. ADDRESS *Baltimore Md.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **43**

1285

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Perry Hall</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Perry Hall</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9401 Belair Rd</u>		STREET ADDRESS (If rural, give location) <u>9401 Belair Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Madeline M. Heying</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Aug 17-1895</u>
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13. FATHER'S NAME <u>Frank Hemminger</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kragle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT AND ADDRESS <u>Mr. John A. Heying 9401 Belair</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Cerebral Hemorrhage</u>		<u>15 minutes</u>	
(b) Antecedent cause(s) <u>Hypertension</u>		<u>10 years</u>	
(c) Other significant conditions <u>Diabetes Mellitus</u>		<u>18 years</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		21. ACCIDENT (Specify) <u>None</u>	
SUICIDE <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
HOMICIDE <u>None</u>		INJURY <u>None</u>	
TIME (Month) (Day) (Year) (Hour) <u>None</u>		HOW DID INJURY OCCUR? <u>None</u>	
22. I hereby certify that I attended the deceased from <u>Jan 5</u> , 19 <u>51</u> , to <u>Feb 22</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Feb 8</u> , 19 <u>51</u> , and that death occurred at <u>2:30</u> p.m., from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (Specify) <u>None</u>	
DATE THEREOF <u>2/23/51</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	
LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>2/23/51</u>		24. FUNERAL DIRECTOR <u>L. A. Rodush</u>	
ADDRESS <u>5305 Harford Rd.</u>		DATE SIGNED <u>2-22-51</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> ---	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home Paradise &amp; Altamont Aves.</u>		STREET ADDRESS (If rural, give location) <u>3308 W. North Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HELEN</u>	(Middle) <u>F.</u>	(Last) <u>HOLLJES</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>11</u>	(Year) <u>19 51</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 13, 1889</u>
9. AGE last birthday <u>61</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Wirt Adams Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Roxannah L. Mitchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT AND ADDRESS <u>Dr. Henry W. D. Holljes - 3308 W. North Ave.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

402.1 Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Myocardial dilatation & failure(b) Atherosclerosis, generalized

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

Atherosclerosis, severe

INTERVAL BETWEEN ONSET AND DEATH

72 hrs.Unknown

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov. 12, 1950, to Feb. 11, 1951, that I last saw the deceased alive on Feb. 10, 1951, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/12/51Dr. W. HedrickWm. J. Tinkner & Sons - Balto390 897 Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Opitz Home Edmondson Ave. &amp; Nunnery Lane</u>		STREET ADDRESS (If rural, give location) <u>504 N. Loudon Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>(May) Mary E. Johnson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 24/51</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 26, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hr. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leonard</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT AND ADDRESS <u>Mrs. Edna Magersupp, 504 N. Loudon Ave.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>6 days</u>
Antecedent cause(s) (b) <u>Arterio sclerosis</u>		<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Ch. nephritis</u>		<u>10 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940, to Feb. 23, 1951, that I last saw the deceased alive on 2/23/51, 1951, and that death occurred at 12:30 A. m., from the causes and on the date stated above.

SIGNATURE Geo. E. Wells (Degree or title) ADDRESS 4100 Edmondson Ave. DATE SIGNED 2/25/51

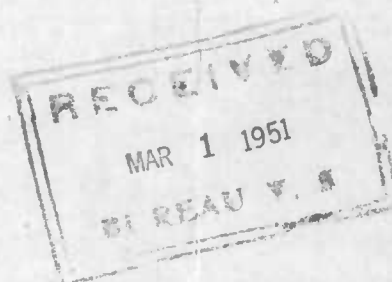
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	LOCATION (City, town, or county) <u>Baltimore</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>2/27/51</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	FUNERAL DIRECTOR <u>Harry N. Wicks</u> ADDRESS <u>Edmondson Ave.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

462





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **1288 33**

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Reisterstown</b>		LENGTH OF STAY (in this place) <b>50 yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Reisterstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Reisterstown Road</b>				STREET ADDRESS (If rural, give location) <b>Reisterstown Road</b>	
3. NAME OF DECEASED (Type or Print)		(First) <b>Bessie</b> (Middle) <b>Elizabeth</b> (Last) <b>Jones</b>		4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>14</b> (Year) <b>1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 27, 1884</b>	9. AGE last birthday <b>61</b> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co.</b>	
13. FATHER'S NAME <b>Eli Tucker</b>		14. MOTHER'S MAIDEN NAME <b>Mary Thomas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>		17. INFORMANT <b>John R. Jones, Reisterstown, Md.</b>	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause (a) <b>Premie trauma</b>					<b>3 days</b>
99d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <b>Myocarditis - chronic decompensating</b>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1-1-30</b> , to <b>2-14-51</b> , that I last saw the deceased alive on <b>2-13-51</b> , and that death occurred at <b>7:4</b> a.m., from the causes and on the date stated above.					
SIGNATURE <b>Samuel S. Saffell M.D.</b>		(Degree or title)		ADDRESS <b>Reisterstown Md</b>	
DATE SIGNED <b>2-15-51</b>					
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Feb. 16, 1951</b>		NAME OF CEMETERY OR CREMATORY <b>St. Lukes</b>	
LOCATION (City, town, or county) <b>Reisterstown, Md.</b>		(State)			
24. FUNERAL DIRECTOR REG. <b>2-15-51</b>		REGISTERAR'S SIGNATURE <b>Dary B. Eline</b>		ADDRESS <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>	

RECEIVED

FEB 20 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1289

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>	
TOWN <u>RANDALLSTOWN</u>		TOWN <u>RANDALLSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LIBERTY RD &amp; GREEN'S LANE</u>		STREET ADDRESS <u>LIBERTY RD &amp; GREEN'S LANE</u>	
3. NAME OF DECEASED (First) <u>WALTER</u> (Middle) <u>WINFIELD</u> (Last) <u>KECK</u>		4. DATE OF DEATH (Month) <u>FEB.</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>FEB. 27 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER</u>	9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN ALFRED KECK</u>		14. MOTHER'S MAIDEN NAME <u>ADELAIDE CLEMENTINE CHILDS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>MRS. WALTER KECK - RANDALLSTOWN MD</u>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154x Immediate cause

(a) CARCINOMA OF RECTUM & METASTASIS

INTERVAL BETWEEN ONSET AND DEATH 1 YEAR

46d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) TO LIVER LUNGS & BRAIN. HYPERTENSIVE C.V. DISEASE

4 YEARS

(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION AUG - 1950

19b. MAJOR FINDINGS OF OPERATION CA. OF RECTUM - & METASTASIS

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE ☒ HOMICIDE ☐ (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY X

INJURY OCCURRED While at Work ☐ Not While At-work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY, 1949, to FEB 8, 1951, that I last saw the deceased

alive on FEB 8, 1951, and that death occurred at 10:35 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 2-12-51

NAME OF CEMETERY OR CREMATORY MT Olive

LOCATION (City, town, or county) Randallstown, Md.

(State)

DATE REC'D BY LOCAL REG. 2/10/51

REGISTRAR'S SIGNATURE Wm. E. Martin

24. FUNERAL DIRECTOR C. A. Wynn - Sykesville, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

740849



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1290

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1147A Courtney Rd. (West Land Gardens)</u>		STREET ADDRESS (If rural, give location) <u>1147A Courtney Rd. (West Land Gdns)</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
	<u>BELLE</u>	<u>LEDLEY</u>	<u>KEIDEL</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 3, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Jacob Ledley</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mr. Charles M. Keidel - Balto. 27, Md.</u>		18. MEDICAL CERTIFICATION <u>1147A Courtney Rd.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Crown Thrombosis</u>		<u>1 day</u>
Antecedent cause(s) (b) <u>hypertension</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-13, 1957, to 2-6-57, 19....., that I last saw the deceased alive on 1-6-57, 19....., and that death occurred at 3:11.....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/8/57</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>	(State)
DATE RECD BY LOCAL REG. <u>2/7/57</u>	REGISTRAR'S SIGNATURE <u>a.w. H. H. H.</u>	24. FUNERAL DIRECTOR <u>Wm. J. Dickener &amp; Sons</u>	ADDRESS <u>Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *52*

1291

1. PLACE OF DEATH COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	
TOWN <i>Pikesville</i> LENGTH OF STAY (In this place) <i>60 yrs</i>		TOWN <i>Pikesville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Reisterstown Road</i>		STREET ADDRESS (If rural give location) <i>Reisterstown Road</i>	
3. NAME OF DECEASED (First) <i>William</i> (Middle) <i>-</i> (Last) <i>Keir</i>	4. DATE OF DEATH (Month) <i>Feb</i> (Day) <i>24</i> (Year) <i>1957</i>		
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Jan 7 1866</i>
9. AGE last birthday <i>85</i> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurseryman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nursery owner</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Joseph Keir</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Wray</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>None</i>	
17. INFORMANT <i>W. Gladstone Keir Pikesville Md</i>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) <i>331x Antecedent cause(s) 83a</i>	(b) <i>Cerebral vascular accident</i>	(c) <i>Hypertension</i>	Interval <i>2 months</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <i>none</i>	19b. MAJOR FINDINGS OF OPERATION <i>-</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1934*, to *23 Feb, 1957*, that I last saw the deceased alive on *23 Feb, 1957*, and that death occurred at *12:15 a.m.*, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

*Paul H. Rayse m. D. Pikesville 8 2nd 24 Feb 57*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Feb 26 1951</i>	NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>	LOCATION (City, town, or county) <i>Pikesville Md</i>
DATE REC'D BY LOCAL REG. <i>2-26-51</i>	REGISTRAR'S SIGNATURE <i>Dr. E. C. Nichols</i>	24. FUNERAL DIRECTOR ADDRESS <i>Wm Berryman &amp; Sons Reisterstown Md</i>	

100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



P. 100  
FEB 27 1951  
BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1292

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lansdowne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lansdowne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2608 Gebb Ave.</u>		STREET ADDRESS (If rural, give location) <u>2608 Gebb Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
	<u>JOHN</u>		<u>KENNER</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 26, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer, retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Conrad Kenner</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Schlichthorn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Matidla Kenner, 2608 Gebb Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
443x Immediate cause 93d Antecedent cause(s)	(a) <u>Cerebral Hemorrhage</u> (b) <u>Hypertension C.V.D.</u> (c)	<u>2 days</u> <u>1 year</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1950, to Feb 25, 1951, that I last saw the deceased alive on Feb 23, 1951, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE <u>Paul Schuchert</u>	(Degree or title)	ADDRESS <u>2301 Annapolis Rd.</u>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>2/27/51</u>	REGISTRAR'S SIGNATURE <u>Paul Schuchert</u>	24. FUNERAL DIRECTOR <u>McMahon</u>	ADDRESS <u>12145 Paul St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970 JUV

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PIKESVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>504 Milford mill Rd.</u>		STREET ADDRESS (If rural, give location) <u>504 Milford mill Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Calvin</u> (Middle) <u>Newton</u> (Last) <u>Kirby</u>	4. DATE OF DEATH (Month) <u>2</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 2-1868</u>
9. AGE last birthday <u>82</u> yrs.		10. UNDER 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>	
11. BIRTHPLACE (State or foreign country) <u>Boonesboro Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Kirby</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mary Julia Kirby - Pikesville, Md.</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arterial Hemorrhage Interval BETWEEN ONSET AND DEATH 2 days

Antecedent cause(s) (b) Hypertension 10 yrs.

(c) Art. & Atherosclerosis 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 24, 1950, to Feb. 23, 1951, that I last saw the deceased alive on Feb. 23, 1951, and that death occurred at 2 A. m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James A. Miller, M.D. Pikesville - B, Md. 2/24/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/24/51</u>	<u>Boonesboro Cemetery</u>	<u>Boonesboro, Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 24-51</u>	<u>Dr. B. C. Michael</u>	<u>Frank H. Powell</u>	<u>Pikesville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE DIRECTOR OF THE FBI

1951

RECEIVED  
FEB 27 1951  
FBI MEMPHIS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1294

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lansdowne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lansdowne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2713 Hammonds Ferry Road</u>		STREET ADDRESS (If rural, give location) <u>2713 Hammonds Ferry Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARGARET</u>	(Middle) <u>V.</u>	(Last) <u>KRAFT</u>
4. SEX <u>Female</u>	5. COLOR OR RACE <u>White</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	7. DATE OF BIRTH <u>May 31, 1881</u>
8. DATE OF DEATH <u>Feb. 17, 1951</u>	9. AGE last birthday <u>69</u> yrs.	10. If under 1 year Months   Days   Hours   Min.	11. If under 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John W. Wales</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Hassett, 2713 Hammonds Ferry Rd.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260x Immediate cause (a).....  
Antecedent cause(s) (b).....  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....

Cerebral Thrombosis  
Arteriosclerosis  
Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 2, 1951, to Jan 17, 1951, that I last saw the deceased alive on Jan 17, 1951, and that death occurred at 11 m., from the causes and on the date stated above.

SIGNATURE

Louis J. Jones MD

ADDRESS

2730 N Charles st

DATE SIGNED

2/19/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2/21/51</u>	<u>Loudon Park</u>	<u>Baltimore, Md.</u>	

DATE REC'D BY LOCAL REG. 2/20/51 REGISTRAR'S SIGNATURE G.W. Hedrick

24. FUNERAL DIRECTOR

ADDRESS

1217 S. Han St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

D. Medical Examiner,  
MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles Street, Baltimore  
**CERTIFICATE OF DEATH**

1295

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b> COUNTY <u>Balto -</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hydes</u> TOWN <u>Hydes</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long Green Road.</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hydes</u> TOWN <u>Hydes</u> STREET ADDRESS (If rural give location) <u>Long Green Road.</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Earl Edward Kress</u> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 9th 1951</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Sept 23 1897</u>
<b>9. AGE last birthday</b> <u>53</u> yrs.	<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Dairy Farm</u>
<b>11. BIRTHPLACE (State or foreign country)</b> <u>Balto - Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Edward Kress</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Heiderfer</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> <u>YES</u>		<b>16. SOCIAL SECURITY No.</b> <u>NONE</u>	
<b>17. INFORMANT</b> <u>Wm Kress</u>			

<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> Immediate cause <u>Accidental death. Killed by his Bull 15 months</u> Antecedent cause(s) <u>Knocked down on the ground</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Causing internal hemorrhage</u> <u>Abdominal and chest injuries, crushing with ruptured</u> <u>Abdominal aorta and hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
<b>11. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		

<b>19a. DATE OF OPERATION</b> <b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>21. ACCIDENT (Specify)</b> <u>Accident</u> <b>PLACE (Home, farm, factory, street, office, etc.)</b> <u>Hydes</u> <b>(CITY OR TOWN) (COUNTY) (STATE)</b> <u>Balto. Md.</u>		<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>John M. Baldwin</u> (Degree or title) ADDRESS <u>2/10/51</u>

<b>23. BURIAL, CREMATION REMOVAL (Specify)</b> <u>Burial</u> <b>DATE THEREOF</b> <u>2/12/51</u> <b>NAME OF CEMETERY OR CREMATORY</b> <u>Balto - Cem -</u> <b>LOCATION (City, town, or county) (State)</b> <u>Baltimore</u>		<b>24. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <u>Bollin C. Hudson Wk., DME, Towson Md. 2/10/51</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>2/12/51</u>		<b>REGISTRAR'S SIGNATURE</b> <u>John M. Baldwin</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1296

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3315 Wash. Blvd.</u>		STREET ADDRESS (If rural give location) <u>3315 Wash. Blvd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frank</u> (Middle)	(Last) <u>Krickler</u>	4. DATE OF DEATH (Month) <u>2/</u> (Day) <u>12/51</u> (Year) <u>19</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>D</u>	8. DATE OF BIRTH <u>Aug. 27, 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone mason</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Ella Cook 3315 Wash. Blvd.</u>			

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
153x Immediate cause	(a) <u>Metastatic Carcinoma Liver and Pancreas</u>	<u>Undet.</u>
462 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Carcinoma of Colon</u>	<u>Undet.</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>1 week.</u>
19a. DATE OF OPERATION <u>3 Feb. 1951</u>	19b. MAJOR FINDINGS OF OPERATION <u>Constructing mass Rt colon, head of Pancreas, nodules in</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1951, to Feb. 12, 1951, that I last saw the deceased alive on Feb. 12, 1951, and that death occurred at 8:20 P. m., from the causes and on the date stated above.

SIGNATURE <u>A. Bradley Sanborn M.D.</u>	(Degree or title)	ADDRESS <u>1264 Francis Ave Halethorpe Md.</u>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>
DATE RECD BY LOCAL REG. <u>2/15/51</u>	REGISTRAR'S SIGNATURE <u>H. H. H. H.</u>	24. FUNERAL DIRECTOR <u>Blarney F. Hoffmann</u>	ADDRESS <u>1639 Broadway</u>

504246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural near White Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural near Parkton</u>	
TOWN <u>Rural near White Hall</u> LENGTH OF STAY (in this place) <u>5 days</u>		TOWN <u>Rural near Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>4 mi West of Parkton</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Charles Edward Lawson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 7, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED - DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 20, 1892</u>
9. AGE last birthday <u>58</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Lawson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>                    </u>	
17. INFORMANT AND ADDRESS <u>Mrs. Gilbert Calhoun, White Hall, Md. R.D.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Chronic myocarditis</u>			
Antecedent cause(s)			
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arterio-sclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/8/51, 1951, to 2/2/51, 1951, that I last saw the deceased alive on 2/1/51, 1951, and that death occurred at 3:20 P.m., from the causes and on the date stated above.

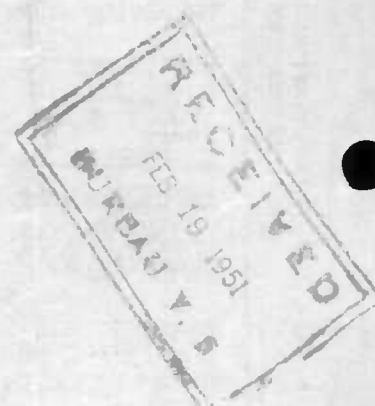
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Febr. 11, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Pine Grove E.B. Cem.</u>	LOCATION (City, town, or county) (State) <u>Parkton, Md. R.D.</u>
DATE REC'D BY LOCAL REG. <u>3/10/51</u>	REGISTRAR'S SIGNATURE <u>Chester L. Bullen</u>	24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>	ADDRESS <u>970105</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1298

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hood Nursing Home</u>				STREET ADDRESS (If rural, give location) <u>517 Kingston Road</u>			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
<u>Mary</u>		<u>L.</u>		<u>Leonard</u>			
4. DATE OF DEATH		(Month)		(Day)		(Year)	
<u>February 21, 1951</u>							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	If under 24 hrs.	
<u>F</u>	<u>W</u>	<u>Widow</u>	<u>10/29/1859</u>	<u>91</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Piedmont Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Francis Demmon</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>No</u>		17. INFORMANT <u>Mr. Ira Leonard 517 Kingston Rd. 29</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
450.0 Immediate cause (a) <u>Arteriosclerosis, generalized</u>						<u>unknown</u>	
Antecedent cause(s) (b) <u>97</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
<u>HOMICIDE</u>		<u>INJURY</u>		<u>Baltimore</u>		<u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 1947, to <u>Feb 20</u> , 1951, that I last saw the deceased alive on <u>Feb 20</u> , 1951, and that death occurred at <u>3:30 P.</u> m., from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>Dr. G. J. Davis M.D.</u>		<u>1 Mallow Hill Ave.</u>		<u>Baltimore Md.</u>		<u>2/22/51</u>	
23. BURIAL, CREMATION REMOVAL, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/24/51</u>		<u>Mt. Olivet</u>		<u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>2/23/51</u>		<u>A W Hedrick</u>		<u>John T. Stansbury 2700 Edmondson Ave.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

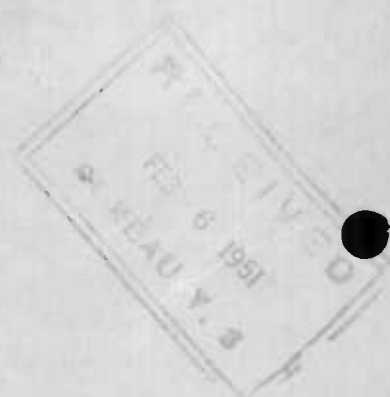
### FOR MEDICAL EXAMINERS

1299

Reg. Dist. No. 33

1. PLACE OF DEATH: COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Balto.</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Reisterstown</b>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Reisterstown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Westminster Road</b>				STREET ADDRESS (If rural, give location) <b>Westminster Road</b>			
3. NAME OF DECEASED (Type or Print)		(First) <b>William</b>		(Middle) <b>Albert</b>		(Last) <b>Little</b>	
4. DATE OF DEATH		(Month) <b>Feb.</b>		(Day) <b>2</b>		(Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7-17-1876</b>	9. AGE last birthday <b>74</b> yrs.	If under 1 year Months Days	If under 24 hrs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Wilmer McHe, Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13. FATHER'S NAME <b>Robert Little</b>				14. MOTHER'S MAIDEN NAME <b>Rachel R. Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY No. <b>214 034103</b>		17. INFORMANT AND ADDRESS <b>Mary Elizabeth Little-(Sister)</b>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Coronary Artery Disease</b>						Undeter-	
Antecedent cause(s) (b) <b>420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b>						mined	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic alcoholism</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<b>None</b>		<b>None</b>					
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <b>None</b>		(CITY OR TOWN) <b>None</b>		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>None</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <b>not an injury</b>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <b>D. D. Caples, M.D. Deputy Med Exam</b>				ADDRESS <b>Reisterstown, Md.</b>		DATE SIGNED <b>2-2-'51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>2-5-15</b>		NAME OF CEMETERY OR CREMATORY <b>Winters</b>		LOCATION (City, town, or county) (State) <b>Carroll Co. Md.</b>	
DATE REC'D BY LOCAL REG. <b>2-2-51</b>		REGISTRAR'S SIGNATURE <b>Mary B. E. Line.</b>		24. FUNERAL DIRECTOR <b>C.M. Waltz</b>		ADDRESS <b>Winfield Md.</b>	

544 358





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1390

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Halethorpe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In The Pines 16 Rusting Ave.</u>		STREET ADDRESS (If rural, give location) <u>1821 Arbutus Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sara</u> (Middle) <u>F. D.</u> (Last) <u>Loney</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 18, 1951</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 16, 1960</u>
9. AGE last birthday <u>91 yrs</u> yrs.		10. AGE last birthday If under 1 year: Months <u>18</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles L. Loney</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT AND ADDRESS <u>Mr. Clifton L. Perkins, Halethorpe, Md.</u>		18. INFORMANT AND ADDRESS <u>1821 Arbutus Ave.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Cerebral Hemorrhage</u>	<u>2 da.</u>
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Ch. Hypertensive Cardio-Vasc. Disease</u>	<u>10 yr.</u>
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-16, 1951, to 2-18, 1951, that I last saw the deceased alive on 2-18, 1951, and that death occurred at 10:50 A.m., from the causes and on the date stated above.

SIGNATURE W. B. Gallagher M.D. ADDRESS 6209 Frederick Ave., Catonsville DATE SIGNED 2-18-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Feb. 20, 1951 NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REG. 2/20/51 REGISTRAR'S SIGNATURE V. E. Harry FUNERAL DIRECTOR W. L. Lamon ADDRESS 4510 Liberty Heights Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>2551 Arunah Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>MIRON</u> (First) (Middle) (Last) <u>(NMI) LUPSA</u>		4. DATE OF DEATH <u>February 7</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-15-94</u>
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Baltimore - Custodian</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>Floyd Lupsa</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) MYOCARDIAL FAILURE, DUE TO

Antecedent cause(s)

(b) HYPERTENSION

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 29, 1951, to Feb. 7, 1951, ~~the date of death~~and that death occurred at 5:37 A.M., from the causes and on the date stated above.

SIGNATURE <u>Irving Freeman</u>	(Degree or title) <u>ACTING</u>	ADDRESS <u>Baltimore, Maryland</u>	DATE SIGNED <u>2-7-51</u>
IRVING FREEMAN, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>2/10/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>2/8/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>	ADDRESS <u>St. Paul &amp; Preston Sts. Baltimore, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

1302

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>VIOLETSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>VIOLETSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1100 TAYLOR AVE.</u>		STREET ADDRESS (If rural, give location) <u>1100 TAYLOR AVE</u>	
3. NAME OF DECEASED (Type or Print) <u>LILLIE ESTELLE LYCETT</u>		4. DATE OF DEATH (Month) <u>FEB.</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEBRUARY 23, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	9. AGE last birthday <u>57 yrs.</u>
13. FATHER'S NAME <u>John E. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA REIDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
(If year, give year or dates of service) <u>NONE</u>		17. INFORMANT AND ADDRESS <u>Mr. Robert Lycett 1100 Taylor Ave</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Coronary Occlusion</u>			<u>20 minutes</u>
260X Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u>			<u>5 mos.?</u>
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes Mellitus</u>			<u>3 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Jan 24, 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>extremity - amputation right hand leg</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan., 1948, to Febr. 17, 1951, that I last saw the deceased alive on Febr. 13, 1951, and that death occurred at 5:45 P.m., from the causes and on the date stated above.

SIGNATURE Earl Pass, M.D. ADDRESS 4001 Wilkens Ave DATE SIGNED Febr 18, 1951

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>Feb. 20, 1951</u>	<u>London Park</u>	<u>BALTIMORE</u>	<u>MD.</u>
24. FUNERAL DIRECTOR	REG'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	ADDRESS	
<u>George L. Schwab</u>	<u>416.19-51</u>	<u>Her Kieffer</u>	<u>2101 Frederick Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC'D  
FEB 28 1951  
BUREAU

Reg. Dist. No. .... 41

VS. A15A

690336



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1304 38

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GOVANS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Govans</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>413 Schwartz Ave.</u>		STREET ADDRESS (If rural, give location) <u>413 Schwartz Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u> (Middle) <u>WILLIAM</u> (Last) <u>MASON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY 3 1947</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 1, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>69</u> yrs.
13. FATHER'S NAME <u>Joseph Mason</u>		14. MOTHER'S MAIDEN NAME <u>Sallie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Joseph Mason - 12019 Fulton Ave.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>CORONARY OCCLUSION</u>	<u>4 hours.</u>	
Antecedent cause(s) (b) <u>ATHEROMA of CORONARY ARTERY of HEART</u>	<u>3 years.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>	<u>10 years.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE <u>none</u> HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not White At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 8, 1948, to February 3, 1951, that I last saw the deceased alive on February 3, 1951, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2-6-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Placid Rest Cem</u>	LOCATION (City, town, or county) (State) <u>Towson Md</u>
DATE REC'D BY LOCAL REG. <u>2/5/51</u>	REGISTRAR'S SIGNATURE <u>A W [Signature]</u>	24. FUNERAL DIRECTOR <u>Mrs. Helen R. Williams 322 N. [Address]</u>	

JT

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 1305

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Margaret V. Matthews

2. DATE  
OF  
DEATH

2-10-51

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

7613 Poplar Ave, Belgate, Md

c. Length of stay in Baltimore

10 yrs

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb 25, 1867

9. AGE (In years;  
last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Dorchester Co. Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wicksten

14. MOTHER'S MAIDEN NAME

Martha

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

None

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

Evelyn H West

ADDRESS

7613 Poplar Ave

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Pulmonary Oedema

INTERVAL BETWEEN  
ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

CORONARY THROMBOSIS

1 month

4201

61

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

HYPERTENSION

15 years

Diabetes

don't know

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1930, 1932, to Feb 10, 1951, that I last saw the  
deceased alive on Feb 10, 1951, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Morris G. Jacobz

M. D.

23B. ADDRESS

1010 NORTH POINT RD

23C. DATE SIGNED

2/11/51

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

2-13-51

24C. NAME OF CEMETERY OR CREMATORY

Brimfield

24D. LOCATION (City, town, or county)

Brimfield, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

2/12/51

REGISTRAR'S SIGNATURE

D.W. Hedrick

25. FUNERAL DIRECTOR

Edward H. Hunsicker

ADDRESS

2503 Edmondson

MARGIN RESERVED FOR BINDING  
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u></u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sand</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oliver Beason R.</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Praskop</u>	(Middle) <u>L.</u>	(Last) <u>Maxa.</u>
4. DATE OF DEATH	(Month) <u>Feb</u>	(Day) <u>17</u>	(Year) <u>51</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 4, 1868</u>
9. AGE last birthday <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired tailor</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Maxa</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Edward Maxa, son, above</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

430.1 Immediate cause (a) Coronary occlusionAntecedent cause(s) (b) Cardiovascular disease  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) diseaseINTERVAL BETWEEN ONSET AND DEATH ImmediateII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

Schlunke Funeral Home, Inc.

ADDRESS

2601-3-5 E. Madison St.

590846

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 130732

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brownsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brownsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Village Julie - Valley Road</u>		STREET ADDRESS (If rural, give location) <u>Village Julie - Valley Road</u>	
3. NAME OF DECEASED (Type or Print) <u>SISTER JOSEPHINE (JULIA McCAFFREY</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 6, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John McCaffrey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fitzgerald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Never</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u>Village Julie - Valley Road</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary thrombosis</u>			<u>4 Mos</u>
Antecedent cause(s) (b) <u>Cancer left breast</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cancer left breast</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov, 1950, to Feb, 1951, that I last saw the deceased alive on Feb 23, 1951, and that death occurred at 6:35 A m., from the causes and on the date stated above.

SIGNATURE <u>Harold H Burns</u>		ADDRESS <u>115 E. Eager St #2 Baltimore Md.</u>		DATE SIGNED <u></u>
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE <u>2-26-51</u>	NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	LOCATION (City, town, or county) <u>Ellicott</u>	(State) <u>md.</u>
DATE REC'D BY LOCAL REG <u>Feb 27-51</u>	REGISTRAR'S SIGNATURE <u>H. E. Michael</u>	24. FUNERAL DIRECTOR <u>George A. Farley - Catonsville, Md.</u>		ADDRESS <u></u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

078888



# MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

Reg. Dist. No. 42

<b>1. PLACE OF DEATH- COUNTY</b> <u>Balto</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Ashtutus</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1232 Vogt ave</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED- STATE</b> <u>Md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ashtutus</u> TOWN STREET ADDRESS (If rural give location) <u>1232 Vogt ave</u>	
<b>3. NAME OF DECEASED (Type or Print)</b> (First) <u>Anne</u> (Middle) <u>R</u> (Last) <u>Meile</u>		<b>4. DATE OF DEATH</b> (Month) <u>Sept</u> (Day) <u>27</u> (Year) <u>1957</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>divorced</u>	<b>8. DATE OF BIRTH</b> <u>April 9 1873</u> <u>77</u> yrs.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>home</u>	<b>11. BIRTHPLACE (State or foreign country)</b> <u>Ind</u>
<b>13. FATHER'S NAME</b> <u>John Cook</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> .	
<b>17. INFORMANT</b> <u>Clarence W. Heitzel</u>		<u>5613</u>	

#### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a)

Acute Cardiac failure

##### Antecedent cause(s)

(b)

Cardio vascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

#### PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

#### SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Geo. H. Kieffer M.D.

1010 Leedson

Sept 27 57

#### 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF 3/3/51

NAME OF CEMETERY OR CREMATORY Greenmount Crematory

LOCATION (City, town, or county) Balto., Md.

(State)

DATE REC'D BY LOCAL REG. 3-2-51

REGISTRAR'S SIGNATURE AB

#### 24. FUNERAL DIRECTOR

ADDRESS

Wm. J. Dickner & Sons - Balto.  
Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1309 37

1. PLACE OF DEATH- COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Ind</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cockeysville</i>		LENGTH OF STAY (in this place) <i>5 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Masonic Home</i>				STREET ADDRESS (If rural, give location) <i>3002 S. Pratt St.</i>	
3. NAME OF DECEASED (Type or Print) <i>Mrs Mary</i>		(First) <i>Magdalena</i>		(Last) <i>Miller</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		4. DATE OF DEATH <i>Feb. 17 - 1951</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <i>Aug. 27-1869</i>		9. AGE last birthday <i>81</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dom home</i>		11. BIRTHPLACE (State or foreign country) <i>Williamsport, Pa</i>	
13. FATHER'S NAME <i>Chas. H. Huber</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Haas</i>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <i>Laura M. Schroeder</i>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
260x Immediate cause (a) <i>Cerebral Accident</i>					
Antecedent cause(s) (b) <i>Diabetes Mellitus</i>					
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2/7</i> , 19 <i>49</i> , to <i>Feb. 17</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>Feb. 17</i> , 19 <i>51</i> , and that death occurred at <i>9:45 P.</i> m., from the causes and on the date stated above.					
SIGNATURE <i>Walter T. Kees</i>		(Degree or title) <i>M.D.</i>		ADDRESS <i>Cockeysville Ind</i>	
DATE SIGNED <i>2-17-51</i>					
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE <i>2/21/51</i>		NAME OF CEMETERY OR CREMATORY <i>David Ridge Cemetery</i>	
LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Ind</i>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <i>Laura M. Schroeder</i>		24. FUNERAL DIRECTOR <i>Wm. Cook</i>	
				ADDRESS <i>St. Paul &amp; Preston St</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 20 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural near White Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural near White Hall</u>	
TOWN <u>West Liberty</u>		TOWN <u>at West Liberty</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>West Liberty</u>		STREET ADDRESS <u>at West Liberty</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles Warren Mitzel</u>		4. DATE OF DEATH <u>Febr. 26</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Febr. 18, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	9. AGE last Birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Curtin E. Mitzel</u>		14. MOTHER'S MAIDEN NAME <u>Maudie E. Little</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>717-07-8334</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Charles W. Mitzel, White Hall, Md.</u>			

### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from lead on arrival, 1951, that I last saw the deceased

alive on 9:00 A.M., 1951, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

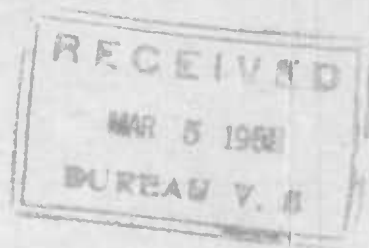
ADDRESS

303506 Penna.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
TOWN <u>109 W. Elm Ave</u>		TOWN <u>109 W. Elm Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Beulah</u> (First) <u>Edna</u> (Middle) <u>Moessinger</u> (Last)		4. DATE OF DEATH <u>Feb 5</u> 19 <u>51</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 9 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year: Months <u>5</u> Days <u>19</u> Hours <u>19</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Greenholt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Fridinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>No one</u>	
17. INFORMANT AND ADDRESS <u>Lawrence L. Moessinger 109 W. Elm Ave</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CEREBRAL HEMORRHAGE</u>			<u>2 1/2 HRS.</u>
Antecedent cause(s) (b) <u>ESSENTIAL HYPERTENSION</u>			<u>7 YRS +</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10/19, 1943, to 2/5, 1951, that I last saw the deceased alive on 2/5, 1951, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

SIGNATURE JOHN W. MACHEN (Degree or title) M.D. ADDRESS 6331 Belair Rd (6) DATE SIGNED 2/5/1951

23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>		<u>FEB 8 1951</u>	<u>MT OLIVET CEMETERY</u>	<u>HANOVER</u>	<u>PENNA.</u>
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>2/7/51</u>		<u>A. W. Hedrick</u>		<u>Duffel Bros. 7110 BELAIR RD.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 13138

1. PLACE OF DEATH - COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Harford Road</u>		STREET ADDRESS (If rural, give location) <u>Old Harford Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Herman</u> (Middle) <u>Moog</u> (Last) <u>Jr.</u>	4. DATE OF DEATH	(Month) <u>Feb.</u> (Day) <u>17</u> (Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH <u>Aug 14, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coach Builder</u>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>79</u> yrs.	If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME <u>Herman Moog</u>	14. MOTHER'S MAIDEN NAME <u>Wilhelmina Zimmerman</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT AND ADDRESS <u>Mrs. Janet Moog Old Harford Rd</u>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

5 years.

## Antecedent cause(s)

(b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

Generalized Arteriosclerosis10 yrs

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

chronic nephritis2 years

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY	m.			

22. I hereby certify that I attended the deceased from Aug., 1945, to Feb. 17, 1951, that I last saw the deceased alive on Feb. 16, 1951, and that death occurred at 9:20 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Crowe Ransom M.D.4808 Harford Rd.2/19/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>2/20/51</u>	<u>Woodlawn</u>	<u>Balto Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/19/51</u>	<u>A. W. Hedrick</u>	<u>L. J. Kuck</u>	<u>5305 Harford Rd.</u>	

JT

290246

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Be Sawyer

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1313

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 2403 Baker Street	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES (Middle) F. (Last) MULES	4. DATE OF DEATH (Month) February (Day) 25 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 11-26-72
9. AGE last birthday 78 yrs.		10. If under 1 year Months Days Hours Mln.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer (unemployed)		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) Baltimore, Maryland		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME David H. Mules		15. MOTHER'S MAIDEN NAME Margaret A. Haddaway	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes SAW		17. SOCIAL SECURITY No. Unknown	
18. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

163x 450.0 Immediate cause	(a) Generalized Arteriosclerosis,	unknown
47d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
(c)		

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.Small carcinoma of the lung with no evidence of tuberculosis  
Tuberculosis, left upper lobe

unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION (5/4/51 akc)	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 20, 1951, to Feb. 25, 1951, and that death occurred at 5:40 P. m., from the causes and on the date stated above.

SIGNATURE Walter R. Benson M.D. ADDRESS VAE, Fort Howard, Md. DATE SIGNED 2-27-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/2/51	NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG. 2-28-51	REGISTRAR'S SIGNATURE a w Redlich	24. FUNERAL DIRECTOR Wm. Cook Funeral Home, St. Paul & Preston Sts. 512 VVV Baltimore, Md.		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **43**

1. PLACE OF DEATH COUNTY <b>Balto. Co.</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MD</b> COUNTY <b>Overlea</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>14 Willows Ave</b>		STREET ADDRESS (If rural, give location) <b>14 Willows Ave</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Bertha K.</b> (Middle) <b>Murphy</b> (Last) <b>Murphy</b>	4. DATE OF DEATH <b>Feb-22-1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept-26-1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE last birthday <b>72 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>David Baumelchissel</b>		14. MOTHER'S MAIDEN NAME <b>Emma Gottschalk</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>44-14848-1</b>	
17. INFORMANT AND ADDRESS <b>Eda Harbaugh-Waynesboro, Pa.</b>			

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4201

Immediate cause

(a) **Acute coronary thrombosis**

INTERVAL BETWEEN ONSET AND DEATH

**Sudden**

93d

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Arteriosclerotic cardiovascular disease**

**Indefinite**

(c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **1949.**, to **Feb 22, 1951.**, that I last saw the deceased

alive on **Dec**, 19**50.**, and that death occurred at **9.15 P.m.**, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

**Francis B. Dickey MD, 715 N. Charles St Baltimore 1, Md.**

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>Feb-26-51</b>	<b>Balto Cem</b>	<b>North Ave. Balto Md.</b>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>2/26/51</b>	<b>RW. H. Smith</b>	<b>John C. Miller</b>	<b>2435 E. Olney St</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 131541

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>340 SAVANNAH AVE.</u>		STREET ADDRESS (If rural, give location) <u>340 SAVANNAH AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LESTER</u> (Middle) <u>STANLEY</u> (Last) <u>TAUGH</u>	4. DATE OF DEATH	(Month) <u>FEB.</u> (Day) <u>3</u> (Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 23, 1902</u>
9. AGE last birthday <u>48</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Thinner</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS TAUGH</u>		14. MOTHER'S MAIDEN NAME <u>LOTTIE BIGGS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>MRS. BESSIE PAUL</u>	
17. INFORMANT <u>340 SAVANNAH AVE</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Coronary Occlusion</u>		
(b) Antecedent cause(s) <u>420, 1</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>940</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE J. J. Davis M.D. (Degree or title) ADDRESS 1111 N. E. Ave. - Dundalk - Md. DATE SIGNED 2/3/51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>FEB. 6, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cem.</u>	LOCATION (City, town, or county) (State) <u>Oakland Garrett Co. MD.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 3 - 1951</u>	REGISTRAR'S SIGNATURE <u>William D. Kelly</u>	24. FUNERAL DIRECTOR <u>Lucy Byers</u>	ADDRESS <u>5005 Park Heights Ave. Balt.</u>

650216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1316

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jefferson, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jefferson, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Road</u>		STREET ADDRESS <u>Falls Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John Robert Peregrine</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 15 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/29/1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer and entrepreneur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Peregrine</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bosson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If year, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Mr. John B. Peregrine, Jefferson, Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Myocarditis</u>			?
Antecedent cause(s) (b) <u>Hypertensive Cardio-renal Vascular Disease</u>			?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 15, 1941, to Feb. 15, 1951, that I last saw the deceased alive on Feb 13, 1951, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE <u>John E. Bush</u>		ADDRESS <u>Md. Hampstead Md</u>		DATE SIGNED <u>Feb 15, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb 19/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Foreston</u>	LOCATION (City, town, or county) <u>Balto Co. Md</u>	(State) <u>Md</u>
DATE RECD BY LOCAL REG. <u>2-18-51</u>	REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	24. FUNERAL DIRECTOR <u>Edw C Tipton, Hampstead Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290116



RECEIVED  
FEB 20 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>BALTIMORE</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Essex</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Essex</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>9 Avenal Ave.</b>		STREET ADDRESS <b>9 Avenal Ave.</b> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <b>IDA</b>	(Middle) <b>V.</b>	(Last) <b>PICKETT</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>July 22, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At. Home</b>	9. AGE last birthday <b>75</b> yrs. If under 1 year Months   Days   Hours   Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Files</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Roth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <b>Mrs. V. Downing - 2932 Cornwall Rd.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

420.1 Immediate cause (a) **Arteriosclerosis C.V. Disease** **Mar 15 50**

93d Antecedent cause(s) (b) **Cerebral vascular Hemorrhage** **Mar 15 50**

(c) **Acute coronary occlusion** **Feb 25 51**

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.**None**

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

**None****None**

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify) <b>None</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>Home</b>	(CITY OR TOWN) <b>None</b>	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	<b>None</b>	INJURY OCCURRED While at <input checked="" type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Mar 15, 1950**, to **Feb 25, 1951**, that I last saw the deceased

alive on **Feb 25, 1951**, and that death occurred at **11:50 p.m.**, from the causes and on the date stated above.

SIGNATURE **Edith H. H. H. H.** (Degree or title) ADDRESS **8428 East Ave** DATE SIGNED **2-27-51**

23. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>3/1/51</b>	NAME OF CEMETERY OR CREMATORY <b>Balto. Cem.</b>	LOCATION (City, town, or county) <b>Balto., Md.</b>	(State)
DATE REC'D BY LOCAL REG. <b>2-27-51</b>	REGISTRAR'S SIGNATURE <b>G. W. Hedrick</b>	24. FUNERAL DIRECTOR <b>Wm. J. Pickner &amp; Sons - Balto.</b>	ADDRESS <b>Md.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto.</u>	
INSTITUTION OR STREET ADDRESS <u>Armacost Nursing Home 812 Register Ave.</u>		STREET ADDRESS (If rural, give location) <u>4138 Roland Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EUPHEMIA</u> (Middle) <u>(EFFIE)</u> (Last) <u>PLENDERLEITH</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 20, 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u>	
13. FATHER'S NAME <u>Wm. Plenderleith</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Adamson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>(If year, give war or dates of service)</u>	
17. INFORMANT AND ADDRESS <u>Mr. J. Douglas Colman - 300 Edgevale Rd.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of mouth and tongue</u>		<u>unknown</u>
Antecedent cause(s) (b) <u>with regional metastases</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of mouth and tongue</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1947, to Feb. 7, 1951, that I last saw the deceased alive on Feb. 7, 1951, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE Wm. L. Surgeon M.D. ADDRESS 11 E Chase St Baltimore Md DATE SIGNED 2/8/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE <u>2/10/51</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>
DATE REC'D BY LOCAL REG. <u>2/9/51</u>	REGISTRAR'S SIGNATURE <u>G. W. Reddick</u>	24. FUNERAL DIRECTOR <u>Wm. J. Lickner &amp; Sons</u>	ADDRESS <u>Balto., Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1318

VVVVVVV

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1319

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5604 Hamilton Ave</u>		STREET ADDRESS (If rural give location) <u>5604 Hamilton Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>William. Henry Price</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 13, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Price</u>		14. MOTHER'S MAIDEN NAME <u>Knopp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Jennie Beard</u>		<u>5604 Hamilton Ave.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary occlusion</u>			<u>1 day</u>
Antecedent cause(s) (b) <u>Arterio-Sclerotic Cardio-Vascular disease</u>			<u>2 years</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 4, 1950, to Feb 4, 1951, that I last saw the deceased alive on Feb 4, 1951, and that death occurred at 6:40 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Geo. M. Baumgardner MD ADDRESS Balto 6 Md. DATE SIGNED Feb 4 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>	LOCATION (City, town, or county) <u>Layton Ave Md.</u>
DATE REC'D BY LOCAL REG. <u>2/5/51</u>	REGISTRAR'S SIGNATURE <u>G. W. Pearson</u>	24. FUNERAL DIRECTOR <u>Mildred J. Blight</u>	ADDRESS <u>6009 Bayford Rd</u>

557

290116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1320 38

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson, Md.</u>		LENGTH OF STAY (in this place) <u>16 yrs 11 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Sheppard &amp; Enoch Pratt Hosp.</u>		<u>21 days</u>		STREET ADDRESS <u>202 Dumbarton Court, 1657 31st St. N. W.,</u>	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>Sarah</u>		<u>Byrd</u>	<u>Pritchett</u>	<u>February</u>	<u>26</u> <u>19 51</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr. 28, 1867</u>	9. AGE last birthday <u>83</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cataloguer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Library</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
13. FATHER'S NAME <u>Carr, Walter Pritchett</u>		14. MOTHER'S MAIDEN NAME <u>Betty Smith</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>HOSPITAL RECORDS</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause

(a) Chronic myocarditis & myocardial degeneration 1 1/2 yrs.93d. Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Generalized Atherosclerosis 20 years

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

Psychosis with Central Atherosclerosis

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 5, 1934, to Feb 26, 1951, that I last saw the deceasedalive on Feb 26, 1951, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

SIGNATURE

J.M. Elgin, M.D.

(Degree or title)

ADDRESS

THE SHEPPARD & ENOCH PRATT HOSPITAL  
Towson, Md.

DATE SIGNED

7/26/51

## 23. BURIAL CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-27-51LJoseph Sanders Sons, 1756 Penna. Ave. N.W., D.C.  
1756 PENNA. AVE. N.W., D.C.  
056 888

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Notch Cliff near Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Baltimore  
 City or town Notch Cliff near Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Sister Mary Asteria Rau

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) Sept. 25, 1863  
 8. AGE: Years 87 Months 4 Days 21 It less than one day  
 hrs. min.

9. Birthplace Buffalo, N.Y.  
 (Town, county, and state)  
 10. Usual occupation Teacher  
 11. Industry or business

12. Name John Rau  
 13. Birthplace Germany  
 14. Maiden name Margaret Paul  
 15. Birthplace Alsace Lorraine

16. Informant Sr. Mary Clara  
 Address Notch Cliff Md

17. BURIAL Date thereof 2-20-51  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory VILLA MARIA  
 Location NOTCH CLIFF NR TOWSON

18. Funeral director Charles J. Feiler  
 Address 901 S. Conkling St. Balt. 24, Md.

19. 2/21 19 51 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1951 at 10.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan 24 1947 to Feb 16 1951  
 and that I last saw him alive on Feb 14 1951

Immediate cause of death Cerebral Aneurysm  
 DURATION  
1 wk

Due to

Due to

Other conditions Atherosclerosis + Hypertension  
420.1  
94a (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Philip H. M.D. M. D. or other

Address 28 Allegheny Ave. Towson Date signed 2-16-51  
09088



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1322

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Ind.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Catonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home in Convalescing Home</u>		STREET ADDRESS (If rural, give location) <u>9 Woodlawn Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>MARSHALL</u>	(Last) <u>READ</u>
4. DATE OF DEATH	(Month) <u>7</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 22, 1866</u>
9. AGE last birthday <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper - Ret.</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Emmons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Leo Read</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Anteriorchotic cardiovascular disease</u>		<u>3 yrs +</u>
Antecedent cause(s) (b) <u>None</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Recurrent arthritis</u>		<u>15-20 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1947, to 4 Feb, 1951, that I last saw the deceased alive on 4 Feb, 1951, and that death occurred at 9:35 P. m., from the causes and on the date stated above.

SIGNATURE John A. Hebert J. M.D. ADDRESS 23 E. Preston St Baltimore 2, Ind DATE SIGNED 5 Feb 51

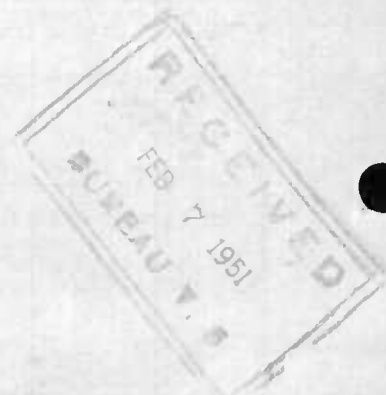
23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2-8-51</u>	<u>Elmwood Cem.</u>	<u>Yorkville, Illinois</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2-6-51</u>	<u>V. E. Harvey</u>	<u>George A. Farley</u>	<u>Catonville, Md.</u>	

700826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1323

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Balt.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>	
TOWN <u>8th Court Rd.</u>		TOWN <u>8th Court Rd.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8th Court Rd.</u>		STREET ADDRESS (If rural, give location) <u>8th Court Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>SAMUEL</u> (First)		4. DATE OF DEATH <u>Feb 1</u> (Month) (Day) (Year) <u>1951</u>	
<u>MATHEW</u> (Middle)		<u>REED</u> (Last)	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan 29, 1878</u>	
9. AGE last birthday <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>	
11. BIRTHPLACE (State or foreign country) <u>Roadside Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Reed</u>	
15. WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs Ida Grace Reed (wife)</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Artery Disease</u>		<u>unknown</u>
Antecedent cause(s) (b) <u>420.1</u> <u>94a</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>	PLACE (Home, farm, factory, street, or office bldg., etc.) <u>none</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>none</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

D. D. Taylor Deputy Med Ex. M.D.

Reisterstown

Feb 1 '51

23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>	LOCATION (City, town, or county) (State) <u>Windsor Mill Ref. Baltos</u>
DATE REC'D BY LOCAL REG. <u>1-3-51</u>	REGISTRAR'S SIGNATURE <u>Dr E E Nichols</u>	24. FUNERAL DIRECTOR <u>Frank H. Quorel</u>	ADDRESS <u>Pikesville, Md</u>

970116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

RECEIVED  
FEB 7 1951  
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1324

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>235 Burke Ave</u>		STREET ADDRESS (If rural give location) <u>235 Burke Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Franklin</u> (Middle) <u>Aaron</u> (Last) <u>Reese</u>	4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7 - 21 - 72</u>
9. AGE last birthday <u>78</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Sullivan, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>John B. Reese</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ellen Miley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Bernadine M. Reese</u>		235 Burke Ave., Towson	

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Heart disease, vascular, coronary occlusion</u>			<u>Sudden 7/7/51</u>
Antecedent cause(s) (b) <u>Cardio-vascular disease, type undetermined</u>			<u>2 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Rollin B. Hudson M.D., D.M.E.</u>		ADDRESS <u>Towson, Md.</u>	
DATE SIGNED <u>2/7/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2 - 10 - 51</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>John O. Mitchell &amp; Sons, Inc.</u>		ADDRESS <u>1900 Eutaw Place Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/8/51</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1325

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Towson  
City or town Baltimore  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution Bellona Ave.  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State New Jersey County \_\_\_\_\_  
City or town Atlantic City Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. Hotel Eastbourne  
(If rural give LOCATION) ✓  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Laura Rehling  
4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

### 6. (b) Name of husband or wife

William Rehling  
6(c) If alive, give age \_\_\_\_\_ years

### 7. Birth date of deceased (mo., day, yr.)

July 31 - 1863

### 8. AGE:

Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### 9. Birthplace

Richmond Va.  
(Town, county, and state)

### 10. Usual occupation

at home

### 11. Industry or business

\_\_\_\_\_

### FATHER

12. Name Carl St. Thilow

### 13. Birthplace

\_\_\_\_\_

### MOTHER

14. Maiden name \_\_\_\_\_

### 15. Birthplace

\_\_\_\_\_

16. Informant Mrs. Rosalie V.R. Kramer

Address 1680 York Ave, N.Y.C.

17. Burial Date thereof 2-16, 1951

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Hollywood Cem.

Location Richmond, Va.

18. Funeral director L. J. Ruck

Address 5305 Hayford Rd - 14

19. 2/15 1951

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14 1951, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-12 1951 to 2-14 1951

and that I last saw him alive on 2-14 1951

Immediate cause of death Arteriosclerotic Cardiovascular Disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 422.1

(Include pregnancy within 8 months of death)

Major findings: 93d

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE P.D. Olsen M.D.

Address 11 E. Chase St. Date signed 2-14-51

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Int 4416

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **38**

1326

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> TOWN <b>Baltimore</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>ARMACOST NURSING HOME</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - R</b> TOWN <b>Baltimore</b> STREET ADDRESS <b>2917 Swift Ave.</b> ADDRESS <b>612 Regester Avenue</b>	
3. NAME OF DECEASED (First) <b>HATTIE</b> (Middle) (Last) <b>REIFNER</b>		4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>15</b> (Year) <b>1951</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Single</b>	8. DATE OF BIRTH <b>1/7/1870</b>
9. AGE last birthday <b>81</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Reifner</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Lindeman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT AND ADDRESS <b>Mr. Henry Doeller, Jr.</b>		201 Southway -18	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>General arteriosclerosis</b>		
Antecedent cause(s) (b) <b>450.0</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>97</b>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) <b>INJURY</b>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept. 11, 1950**, to **Feb. 15, 1951**, that I last saw the deceased alive on **Feb. 14, 1951**, and that death occurred at **6.30 a.m.**, from the causes and on the date stated above.

SIGNATURE **W. J. Schmitt** (Degree or title) ADDRESS **701 N. Kenwood Ave.** DATE SIGNED **Feb. 16, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>2-17-51</b>	NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE REC'D BY LOCAL REG. <b>2-16-51</b>	REGISTRAR'S SIGNATURE <b>W. J. Schmitt</b>	24. FUNERAL DIRECTOR & ADDRESS <b>H. SANDER &amp; SONS, INC. BALTO., MD.</b>	

093 888

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1327

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX RIVER</u>	
TOWN <u>ESSEX</u>		TOWN <u>ESSEX RIVER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4 EDGEWATER TERRACE</u>		STREET ADDRESS (If rural give location) <u>4 EDGEWATER TERRACE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HERMAN</u>	(Middle) <u>EZRA</u>	(Last) <u>Richardson</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>27</u>	(Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JANUARY 9, 1887</u>
9. AGE last birthday <u>64 yrs.</u>	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machineist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PIPE NIPPLES</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John V. Richardson</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE MILLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>213-09-3476</u>	
(If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>Mrs. Fredericka Richardson</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset and Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
163x Immediate cause (a) <u>Carcinoma of Left Lung</u>		
47d Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED White at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>50</u> , to <u>2/27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>2/13</u> , 19 <u>51</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.		
SIGNATURE <u>John H. Goodman</u>		DATE SIGNED <u>2/27/51</u>
(Degree or title) <u>M.D.</u>		ADDRESS <u>3400 E. Baltimore W</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>	<u>3-5-51</u>	<u>London PARK</u>
LOCATION (City, town, or county) (State)	<u>BALTIMORE</u> <u>MD.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>3-1-51</u>	<u>N.W. Hedrick</u>	<u>GEO. L. Schwab</u>
ADDRESS <u>2101 FREDERICK AVE.</u>		

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

544 VVV

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1328

Reg. Dist. No. **39**

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Phoenix</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Phoenix</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Dulaney Valley Road</b>		STREET ADDRESS (If rural, give location) <b>Dulaney Valley Road</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>GEORGE</b> (Middle) <b>CLARENCE</b> (Last) <b>RISHER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>February 2, 1951</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>Dec. 4, 1950</b>
9. AGE last birthday <b>2</b> yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>2</b> Mins.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Babe</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland - Harford Co.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Edmond Risher</b>	
14. MOTHER'S MAIDEN NAME <b>Dorothy Pearl Sible</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Charles E. Risher (father)</b>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Otitis media, left ear**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. **Aspiration of vomitus**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <b>home</b>	(CITY OR TOWN) <b>Dulaney Valley Rd. Phoenix, Baltimore, Md.</b>	(COUNTY) <b>Baltimore</b>	(STATE) <b>Md.</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Feb. 2, 1951 4 a.m.</b>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <b>Apparently regurgitated formula and choked</b>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>BURIAL</b>	<b>Feb. 5, 1951</b>	<b>Prospect Hill Cemetery</b>	<b>Towson, Md.</b>	<b>Md.</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<b>2/6/51</b>	<b>G. W. Hedrick</b>	<b>John Burns' Sons, Towson, Md.</b>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No. 1166

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1329 33

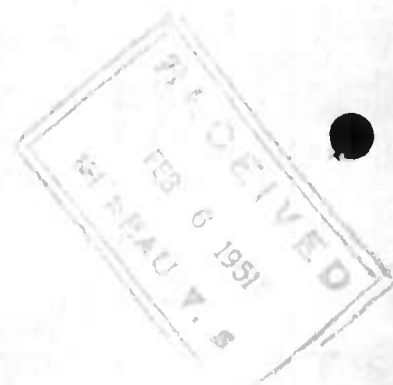
1. PLACE OF DEATH COUNTY <u>Baldwin</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u> LENGTH OF STAY (in this place) <u>2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hanover Road</u>		STREET ADDRESS (If rural give location) <u>Hanover Road</u>	
3. NAME OF DECEASED (Type or Print) <u>ANNA</u>	(First) <u>MARIE</u>	(Last) <u>ROLF</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY 2 1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 13, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65</u> yts. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>John Redding</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schuman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give dates of service) <u>None</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Hilton Jacobson, Reisterstown, Md.</u>			

18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CORONARY THROMBOSIS</u>		<u>4 HRS.</u>
Antecedent cause(s) (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u>		<u>10 YRS.</u>
(c) <u>DIABETES MELLITUS</u>		<u>10 YRS.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>MAY</u> , 19 <u>50</u> , to <u>FEB. 2</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>FEB. 2</u> , 19 <u>51</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.		
SIGNATURE <u>Martin E. Strobel</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Reisterstown Md.</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 5, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>
LOCATION (City, town, or county) <u>Baltimore City</u>	(State)	
DATE REC'D BY LOCAL REG. <u>2-3-51</u>	REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	24. FUNERAL DIRECTOR <u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1330

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore County</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1 S. Crook Road - Box 391</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u>	(Middle) <u>W.</u>	(Last) <u>ROZIER</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2-17-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk.</u>	9. AGE last birthday <u>56</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nelson Rozier</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alberts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) ATELECTASIS, RIGHT LUNG  
DILATATION AND HYPERTROPHY RIGHT VENTRICLE AND  
AURICLE

INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN  
UNKNOWN

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

None

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐  
 (STATE)

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
 INJURY

(CITY OR TOWN)

(COUNTY)

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED  
 While at Not While  
 Work ☐ At work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 23, 1950, to Feb. 6, 1951, that I last saw the deceased

XXXXXX and that death occurred at 5:20 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND 2-7-51

## 23. BURIAL CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR'S

ADDRESS

Wm. Cook, Inc. Saint Paul & Preston Sts.  
Baltimore, Maryland

JTV

970VVV

Baltimore, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1331  
Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>		STREET ADDRESS <u>16 Rusting Ave. Convalescent Home</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u> (Middle) <u>FREDERICK</u> (Last) <u>RUOFF</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>21st.</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>6/13/1860</u>
9. AGE last birthday <u>90 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Ruoff</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hetzner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Brooks Lipscomb Catonsville, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral Hemorrhage

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardio-Vascular Disease & Hypertension(c) Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

1 day3 yrs1 yearII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4/5, 1948, to 2/21, 1951, that I last saw the deceased alive on 2/20, 1951, and that death occurred at 12:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2/23/51</u>	<u>Loudon Park</u>	<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/23/51</u>	<u>V.E. Harry</u>	<u>Easton Sons</u>	<u>Catonsville, Md.</u>	

290 696

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1332

Reg. Dist. No. 45

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u> (Middle) <u>J.</u> (Last) <u>Sauer</u>	4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec 3 1883</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Sauer</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Matilda Dausch</u>		18. MEDICAL CERTIFICATION <u>Sister</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>3rd Degree Burns Upper 1/2 of body</u>		
(b) Antecedent cause(s) <u>917-0</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>181</u>		
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u> CITY OR TOWN <u>Middle River</u> (COUNTY) <u>Balto</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-12-51-7:45</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Burned in home</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE Dr. David M. S. Ryan - Dundalk, Md. (Degree or title) ADDRESS 1800 E. Lombard St DATE SIGNED 2/13/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb 13-51</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) <u>Belair Rd Balto Md</u> (State)
DATE RECD BY LOCAL REG. <u>2/13/51</u>	REGISTRAR'S SIGNATURE <u>Dr. David M. S. Ryan</u>	24. FUNERAL DIRECTOR <u>Joseph B. ...</u>	ADDRESS <u>1800 E. Lombard St</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1333

38

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Carney</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carney</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9834 Harford Rd.</u>		STREET ADDRESS (If rural, give location) <u>9834 Harford Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Gertrude A. Laurin</u>		4. DATE OF DEATH <u>Feb. 19 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>June 13-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>2</u>		12. CITIZEN OF WHAT COUNTRY?	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>2</u>	
15. SOCIAL SECURITY NO.		16. INFORMANT <u>Mr. Mary G. Norris, 9834 Harford</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

442x

131a

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 days

2 years

2 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Feb 19, 1951, that I last saw the deceasedalive on Feb 19, 1951, and that death occurred at 3-10 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



DR. GONZALEZ

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1334 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Owings Mills Md.</u>		STREET ADDRESS (If rural give location) <u>Plesent Hill &amp; Reisterstown R</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Lillian T. Schneider</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2/1/51</u> 19 <u>51</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>9/30/1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>70</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Quinn</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT <u>Marie Bransfield</u>		<u>Owings Mills Md.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) PULMONARY EDEMA

INTERVAL BETWEEN ONSET AND DEATH

4 DAYS

Antecedent cause(s)

(b) HYPERTENSIVE - ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE 6 YEARS

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from MARCH, 1950., to FEBRUARY 1, 1951., that I last saw the deceased

alive on JAN. 31, 1951., and that death occurred at 4:00 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Martin E. Strobel

M.D.

Reisterstown, Md.

2/1/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) <u>Baltimore Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2/1/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>John T. Stansbury</u>	ADDRESS <u>2700 Edmondson Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <i>Balto.</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>MD.</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Balto.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hood Nursing Home</i>				STREET ADDRESS <i>5440 Frederick Rd.</i> ✓	
3. NAME OF DECEASED (Type or Print) <i>Margaret</i>		(First) (Middle) (Last) <i>Schwartz</i>		4. DATE OF DEATH <i>Feb. 25-</i> 19 <i>51</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W.</i>	8. DATE OF BIRTH <i>Nov 24-1872</i>	9. AGE last birthday <i>78</i> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
13. FATHER'S NAME <i>Thomas W. Ruth.</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Seth.</i>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>-</i>		17. INFORMANT AND ADDRESS <i>Frederick Alice Simmons 53 E Patrick St</i>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
192x Immediate cause (a) <i>Degenerative C. v. D.</i>					<i>2 wks</i>
55e Antecedent cause(s) (b) <i>Sarcoma of L. Eye</i>					<i>2 yrs</i>
(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9-12</i> , 19 <i>50</i> , to <i>2-25</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>2-25</i> , 19 <i>51</i> , and that death occurred at <i>7 A</i> m., from the causes and on the date stated above.					
SIGNATURE <i>James Asstowell</i>		(Degree or title)		ADDRESS <i>Catonsville</i> DATE SIGNED <i>2-27</i>	
23. BURIAL, CREMATION REMOVED (Specify)		DATE THEREOF <i>2/27/51</i>		NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>	
LOCATION (City, town, or county) <i>Balto</i>		(State) <i>MD</i>			
DATE REC'D BY LOCAL REG. <i>2-27-51</i>		REGISTRAR'S SIGNATURE <i>a w Hedrick</i>		24. FUNERAL DIRECTOR <i>Wm Cook Inc. 1217 St Paul St</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change  
in 8 shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1336

FILM No. G 130 FEB 19 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>624 Sussex Rd.</u>				STREET ADDRESS (If rural, give location) <u>624 Sussex Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>THOMAS</u>		(First) <u>B.</u> (Middle)		(Last) <u>SCOTT</u>	
6. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		4. DATE OF DEATH <u>Feb. 8, 1951</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sept. 17, 1885</u>		9. AGE last birthday <u>64</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operation Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Patrick Scott</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hyland</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>		17. INFORMANT AND ADDRESS <u>Mrs. Madalina S. Scott - 624 Sussex Rd.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause  
Antecedent cause(s)  
94a Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(a) Dissecting Aortic Aneurysm  
(b) Coronary Thrombosis  
(c)

INTERVAL BETWEEN  
ONSET AND DEATH

12 hours

4 yrs

#### 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,  
SUICIDE OF office bldg., etc.)  
HOMICIDE INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED  
OF While at Not While  
INJURY Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/7, 1951, to 2/8, 1951, that I last saw the deceased

alive on 2/8, 1951, and that death occurred at 2:15 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)  
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

February 10, 1951

R.W.

Wm. J. Dickner & Sons - Balto., Md.

290618

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 13838

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1625 E. Joppa Road</b>		STREET ADDRESS (If rural, give location) <b>1625 E. Joppa Road</b>	
3. NAME OF DECEASED (Type or Print) <b>WALTER STRAUGHN SHUE</b>	4. DATE OF DEATH <b>Feb. 4, 1951</b>	5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Aug. 4, 1908</b>	9. AGE last birthday <b>42</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Granville S. Shue</b>		14. MOTHER'S MAIDEN NAME <b>Cora Belle Patterson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY No. <b>217-03-5820</b>	
17. INFORMANT AND ADDRESS <b>Mrs. Evelyn B. Shue, Towson, Maryland</b>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Pulmonary edema</b>			
Antecedent cause(s) (b) <b>Old rheumatic heart disease</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>None</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED White at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1/1, 1948, to 2/4, 1951, that I last saw the deceased alive on 2/4, 1951, and that death occurred at 8:45 P m., from the causes and on the date stated above.

SIGNATURE Gordon Egan MD ADDRESS 8513 Loch Raven Blvd Towson Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>Feb. 7, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	LOCATION (City, town, or county) <b>Parkville, Maryland</b>	(State)
DATE REC'D BY LOCAL REG. <b>2/6/51</b>	REGISTRAR'S SIGNATURE <b>G. W. Hedrick</b>	24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>	ADDRESS	

ST

510246

MARGIN RESERVED FOR BINDING

VS. A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# CERTIFICATE OF DEATH

Reg. Dist. No. 40

VS-A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Balto, Co</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto, Co</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sunshine Ave. Upper Falls, Md</u>		STREET ADDRESS (If rural, give location) <u>Sunshine Ave. Upper Falls, Md</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles</u>		4. DATE OF DEATH <u>Feb 10 1951</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>May 7-1868</u>	
9. AGE last birthday <u>82 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Sisson</u>		14. MOTHER'S MAIDEN NAME <u>Willie Webb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Wm Mohr Sunshine Ave. Upper Falls</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Carcinoma of bladder &amp; prostate</u>		<u>1 yr.</u>	
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		<u>arteriosclerotic hypertensive heart disease 5 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from <u>5-11</u> , 19 <u>50</u> , to <u>2-10</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>2-9</u> , 19 <u>51</u> , and that death occurred at <u>2 P</u> m., from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>Thos O Hodous M.D.</u>		ADDRESS <u>Edgewood Md</u> DATE SIGNED <u>2-11-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>For K. Christian Cem</u>	
DATE REC'D BY LOCAL REG <u>2/11/51</u>		LOCATION (City, town, or county) <u>Balto Co Md</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Lassell Funeral Home 7401 Balair Rd.</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **XX**

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hosp.</b>		STREET ADDRESS (If rural, give location) <b>2728 Ellicott Driveway</b>	
3. NAME OF DECEASED (First) <b>OTIS</b> (Middle) <b>F.</b> (Last) <b>SMALL</b>		4. DATE OF DEATH (Month) <b>February</b> (Day) <b>23</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9/27/11</b>
9. AGE last birthday <b>39</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Franklin Small</b>		14. MOTHER'S MAIDEN NAME <b>Mary McKay</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY No. <b>212-14-8389</b>	
17. INFORMANT AND ADDRESS <b>Clin. Records, Vet. Adm. Hosp., Ft. Howard, Md.</b>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **BRONCHOGENIC CARCINOMA**

INTERVAL BETWEEN ONSET AND DEATH

**2 yrs. plus**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **DIFFUSE WIDESPREAD METASTASES**

**Unknown**

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) <b>HOMICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Oct. 28, 1951, to Feb. 23, 1951**, and that I saw the deceased

die on **Feb. 23, 1951**, and that death occurred at **6:40 a.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**IRVING FREEMAN, M.D., ACT. CHIEF, MEDICAL SERVICE, VET. ADM. HOSP. FT. HOWARD, MD 2/23/51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>2/26/51</b>	NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	LOCATION (City, town, or county) <b>Baltimore, Md.</b>	(State)
DATE REC'D BY LOCAL REG. <b>2/26/51</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	24. FUNERAL DIRECTOR <b>Wm. Cook Funeral Home</b>	ADDRESS <b>St. Paul &amp; Preston St Balto. Md.</b>	

**583-246**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence for change  
in 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1340

FILE No. G 130 FEB 16 1951

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>ARMAGH VILLAGE</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>209 N. Tyrone Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>BALTO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>NANTICOKE</u> TOWN STREET ADDRESS (If rural, give location) <u>84 Prospect Street</u>	
3. NAME OF DECEASED (Type or Print) <u>ABIJAH</u> (First) <u>D.</u> (Middle) <u>SMITH</u> (Last)		4. DATE OF DEATH <u>Feb. 8, 1951</u> (Month) (Day) (Year)	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Feb. 22, 1871</u> 9. AGE last birthday <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis Draper Smith</u>		14. MOTHER'S MAIDEN NAME <u>Susan -- Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Wm. R. Sisley - 209 N. Tyrone Rd.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u> (a) <u>Coronary Thrombosis due to Arterio-sclerosis</u>		<u>48 hrs.</u>
Antecedent cause(s) <u>94a</u> (b) <u>Coronary Heart Disease - Angina Pectoris</u>		<u>10 years +</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 7, 1951, to Feb. 8, 1951, that I last saw the deceased alive on Feb. 8, 1951, and that death occurred at 11:05 Am. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
Robert W. Garis, M.D. F.A.C.P. - 1103 St. Paul St. Baltimore-2, Md. 2/8/51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	DATE <u>2/8/51</u>	NAME OF CEMETERY OR CREMATORY <u>Hanover Green Cem.</u>	LOCATION (City, town, or county) <u>Hanover Township, Pa.</u>
DATE REC'D BY LOCAL REG. <u>2/8/51</u>	REGISTRAR'S SIGNATURE <u>G. W. Redner</u>	24. FUNERAL DIRECTOR <u>Wm. J. Lickner &amp; Sons - Balt.</u>	ADDRESS <u>Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

643846

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1341  
Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>20</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Centreville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vet. Adm. Hosp., Ft. Howard, Md.</b>		STREET ADDRESS (If rural, give location) <b>Box 333</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>RAYMOND</b> (Middle) <b>E.</b> (Last) <b>SMITH</b>	4. DATE OF DEATH (Month) <b>February</b> (Day) <b>11</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>10-29-88</b>
9. AGE last birthday <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture finisher</b>	
11. BIRTHPLACE (State or foreign country) <b>Centreville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Smith</b>		14. MOTHER'S MAIDEN NAME <b>Sally Ann Ryan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY No. <b>214-03-1458</b>	
17. INFORMANT AND ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **LYMPHOSARCOMA**

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

**6 months**

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**Arteriosclerotic Cardiovascular disease**

**1 year**

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Feb. 6, 1951**, to **Feb. 11, 1951**, that last saw the deceased

**XXXXXXXXXXXXXXXX**, and that death occurred at **5:30 P.m.**, from the causes and on the date stated above.

SIGNATURE **Irving Freeman** (Degree or title) ADDRESS DATE SIGNED

**IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 2-12-51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>2/14/51</b>	NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>	LOCATION (City, town, or county) (State) <b>Centreville, Maryland</b>
DATE REC'D BY LOCAL REG. <b>Feb. 12-51</b>	REGISTRAR'S SIGNATURE <b>Lawson J. Farber</b>	24. FUNERAL DIRECTOR <b>Lane Funeral Home Church Hill, Maryland</b>	

670309

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Sparks-rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Sparks-rural</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>intentionally life</u>		STREET ADDRESS <u>1730 St. Paul Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Reverdy Benson Sparks</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 24 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec 12-1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Logistics</u>	
11. BIRTHPLACE (State or foreign country) <u>Sparks, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Shadrach L. Sparks</u>		14. MOTHER'S MAIDEN NAME <u>Jessamine Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>415-01-5293</u>	
17. INFORMANT AND ADDRESS <u>Richard B. Sparks Jr. Sparks, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cornary occlusion</u>				<u>5 min.</u>	
Antecedent cause(s) (b) <u>Cornary sclerosis</u>				<u>5 yr.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u></u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u>		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u></u>	
22. I hereby certify that I attended the deceased from <u>Feb 20, 1951</u> , to <u>Feb 24, 1951</u> , that I last saw the deceased alive on <u>Feb 23, 1951</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Elizabeth B. Shumill M.D.</u>		ADDRESS <u>Cockeysville, Md.</u>		DATE SIGNED <u>2/24/51</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>2-27-51</u>		NAME OF CEMETERY OR CREMATORY <u>Jessamine Methodist</u>	
LOCATION (City, town, or county) (State) <u>Sparks, Baltimore, Md.</u>		24. FUNERAL DIRECTOR <u>J. Scott Brooks</u>		ADDRESS <u>Sparks, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/26/51</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Chilcoat</u>			

290626

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## 1343

# CERTIFICATE OF DEATH

Reg. Dist. No. 500

1. PLACE OF DEATH- COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		Catonsville		LENGTH OF STAY (in this place)		25 Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR		Catonsville	
TOWN		Catonsville		HOSPITAL OR INSTITUTION OR STREET ADDRESS		7 Overbrook Road		STREET ADDRESS		(If rural, give location) 7 Overbrook Road	
3. NAME OF DECEASED (Type or Print)		(First) Thomas		(Middle) Fletcher		(Last) Spicknall		4. DATE OF DEATH		(Month) (Day) (Year) Feb. 15, 1951	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Dec. 5, 1876		9. AGE last birthday 78 yrs.		If under 1 year Months Days Hours Min. If under 24 hrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.		11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas S. Spicknall						14. MOTHER'S MAIDEN NAME Dorcas Ireland					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no				16. SOCIAL SECURITY No. none		17. INFORMANT AND ADDRESS Mrs. Alida L. Spicknall 7 Overbrook Rd					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

### INTERVAL BETWEEN ONSET AND DEATH

4201 Immediate cause (a) myocardial infarction, acute

94a Antecedent cause(s) (b) generalized arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

17 yrs

**II. OTHER SIGNIFICANT CONDITIONS**  
Conditions contributing to the death but not related to the disease or condition causing death.

Arterial Hypertension

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE				(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month)	(Day)	(Year)	(Hour)		INJURY OCCURRED
OF					While at Work      Not While
INJURY			m.		Work <input type="checkbox"/> At work <input type="checkbox"/>

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
<p>22. I hereby certify that I attended the deceased from <u>Nov.</u>, 19<u>50</u>, to <u>Feb. 14</u>, 19<u>51</u>, that I last saw the deceased alive on <u>Feb. 14</u>, 19<u>51</u>, and that death occurred at <u>4:45</u> <u>PM</u>, from the causes and on the date stated above.</p> <p>SIGNATURE _____ (Degree or title) ADDRESS _____ DATE SIGNED _____</p>		

2. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-17-1951	Loudon Park	Baltimore	Md.
DATE DEC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
2/16/51	<i>G. Howard Strong</i>	G. Howard Strong	3207 W. North Ave..	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1344

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE		Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		Lutherville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		Lutherville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		North & Kurtz Aves.		STREET ADDRESS		(If rural, give location)		North & Kurtz Avenue			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
Joseph		D.		Stack, Sr.		Feb.		11		1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year		If under 24 hrs.	
Male	White	Widowed		11/26/64		86 yrs.		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		U. S. A.			
Retired Contractor & Builder				Baltimore, Md.							
13. FATHER'S NAME		John Stack		14. MOTHER'S MAIDEN NAME		Ellen Kelly					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If year, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS		Mrs. Elizabeth S. Carroll, Lutherville			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) Heart disease, chronic myocarditis		10 yrs.	
Antecedent cause(s)		(b) Heart disease, vascular, coronary with thrombosis		10 yrs	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) Arteriosclerosis (with senile cachexia)		Unknown	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept, 1948, to Feb 11, 1951, that I last saw the deceased alive on Feb 11, 1951, and that death occurred at 9:50 P.m., from the causes and on the date stated above.

SIGNATURE William B. Hudson MD. ADDRESS Towson Md DATE SIGNED 2/12/51

23. BURIAL-CREATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial 2/15/51 New Cathedral Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS

W. W. Meeks and Son 805 N. Calvert St

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-413

290246

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1345

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1646 Eastern Ave.</b>		STREET ADDRESS (If rural give location) <b>1646 Eastern Ave.</b>	
3. NAME OF DECEASED (Type or Print) <b>Margaret J. Steele</b>		4. DATE OF DEATH (Month) <b>2</b> (Day) <b>1</b> (Year) <b>1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11-8-1860</b>
9. AGE last birthday <b>90</b> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Richard Madock</b>		14. MOTHER'S MAIDEN NAME <b>Mary Doyle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY No. <b>-</b>	
17. INFORMANT <b>Wm. W. Steele</b>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Arterio-sclerotic Cardio-vascular Disease</b>		<b>3 yrs</b>	
Antecedent cause(s) (b) <b>422.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b>			
Other significant conditions (c) <b>no</b>			
11. OTHER SIGNIFICANT CONDITIONS			
19a. DATE OF OPERATION <b>no</b>		19b. MAJOR FINDINGS OF OPERATION <b>no</b>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 1st</b> , 19 <b>50</b> , to <b>Feb 1st</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>Feb 1st</b> , 19 <b>51</b> , and that death occurred at <b>11:54 a.m.</b> , from the causes and on the date stated above.			
SIGNATURE <b>James H. White M.D.</b>		ADDRESS <b>422 Eastern Ave., Baltimore 21, Md.</b>	
DATE SIGNED		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>2-3-1951</b>	
NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
DATE REC'D BY LOCAL REG. <b>2/2/51</b>		REGISTRAR'S SIGNATURE <b>John E. Moran</b>	
24. FUNERAL DIRECTOR		ADDRESS <b>3000 E. Baltimore St.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

T

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1346 50

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rev. A. Opitz Home</u>		STREET ADDRESS (If rural, give location) <u>4213 Belmar Avenue</u>	
3. NAME OF DECEASED (First) <u>ALBERT</u> (Middle) (Last) <u>STEPANEK</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar. 26, 1873</u>
9. AGE last birthday <u>77</u> yrs.		10. If under 1 year: Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dvorak Bros.</u>	
11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Stepanek</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Jos. M. Stepanek - son, above</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CEREBRAL HEMORRHAGE, RECURRENT.

INTERVAL BETWEEN ONSET AND DEATH

6 mos

Antecedent cause(s)

(b) 331X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 25, 1951, to Feb 3, 1951, that I last saw the deceasedalive on Feb 2, 1951, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 5, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	LOCATION (City, town, or county) <u>4430 Belair Rd. Balto. Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2/5/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Schmidner Funeral Home, Inc.</u>	ADDRESS <u>2601-3-5 E. Madison St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1347

Evidence for change  
in #9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

FILE No. G 151 MAR 6 1951

1. PLACE OF DEATH COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MD.</b> COUNTY <b>BALTO.</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>GRAY MANOR</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>GRAY MANOR</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>309 GERMAN HILL ROAD</b>		STREET ADDRESS (If rural, give location) <b>309 GERMAN HILL ROAD</b>	
3. NAME OF DECEASED (First) <b>JOHN</b> (Middle) <b>EDWARD</b> (Last) <b>STOCKUM</b>		4. DATE OF DEATH (Month) <b>FEB</b> (Day) <b>18</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 22, 1870</b>
9. AGE last birthday <b>81</b> yrs.		10. If under 1 year Months <b>1</b> Days <b>18</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Marietta, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Stockum</b>		14. MOTHER'S MAIDEN NAME <b>Barbara (?)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>705-10-9731</b>	
17. INFORMANT <b>Edw. J. Stockum, (Son)</b>			

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

#### Immediate cause

(a) **① Arterio - Sclerotic - Cardio - Vascular**

#### Antecedent cause(s)

(b) **Disease**  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) **① Senility**

INTERVAL BETWEEN ONSET AND DEATH

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) **INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

ADDRESS

ADDRESS

**Feb. 20-1951 William M. Kelly Jr.**

**Walter Brooks Bradley, Dundalk, Md.**

541506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A



RECEIVED  
FEB 23 1961  
BUREAU V.P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Evidence for additional MARYLAND STATE DEPARTMENT OF HEALTH  
in 21 shown on:

# CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

1348

FILM No. G 150 FEB 13 1951

Reg. Dist. No. 49

1. PLACE OF DEATH COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>SPARROWS POINT</b>			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Sparrows Point</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6976 OLD NORTH PT. RD. WELLS AVE</b>			STREET ADDRESS (If rural, give location) <b>3005 Wells Avenue</b>		
3. NAME OF DECEASED (Type or Print) (First) <b>GEORGE</b> (Middle) <b>WALTER</b> (Last) <b>SUMMERS</b>			4. DATE OF DEATH (Month) <b>February</b> (Day) <b>4</b> (Year) <b>1951</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>JAN 14, 1910</b>	9. AGE last birthday <b>41</b> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BETH-STEEL CO.</b>		
11. BIRTHPLACE (State or foreign country) <b>CATAWBA, W. VA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>WILLIAM L. SUMMERS</b>			14. MOTHER'S MAIDEN NAME <b>FLORENCE SWISHER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>123-07-9629</b>		
17. INFORMANT <b>MARY M. SUMMERS 3005 WELLS AVE</b>					

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Skull fracture**

Antecedent cause(s)

(b) **Subdural hemorrhage**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <b>Street</b>	(CITY OR TOWN) <b>Old North Point Road &amp; Wells Ave.</b>	(COUNTY) <b>BALTIMORE</b>	(STATE) <b>Md.</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Feb. 2, 1951</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <b>Fell down steps while intoxicated (2/13/51 aka)</b>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*William L. Summers*

700 Fleet St., Balto. 2, Md.

Feb. 5, 1951

23. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF <b>2/8/51</b>	NAME OF CEMETERY OR CREMATORY <b>DAK LAWN</b>	LOCATION (City, town, or county) (State) <b>EASTERN BLVD BALTO. MD.</b>
DATE REC'D BY LOCAL REG. <b>2/7/51</b>	REGISTRAR'S SIGNATURE <i>A.W. Hedrick</i>	24. FUNERAL DIRECTOR <b>WILLIAM FUNERAL HOME, DUNDALK MD.</b>	ADDRESS <b>533 336</b>

JT

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1349

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balts</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
TOWN <u>Catonsville</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1942 Powers Lane</u>		STREET ADDRESS (If rural give location) <u>1942 Powers Lane</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Louis</u> (Middle) <u>Charles</u> (Last) <u>Uebel</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>3</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. <del>SINGLE, MARRIED,</del> WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3-2-11</u>
9. AGE last birthday <u>39</u> yrs.		10. AGE last birthday (If under 1 year) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis C Uebel</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Kromer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Mrs George Dawson Catonsville Md</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Epileptic seizure</u>			
Antecedent cause(s) (b) <u>85</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Epilepsia</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>Dr. M. Kieffer M.D.</u>		DATE SIGNED <u>July 5, 57</u>	
ADDRESS <u>1010 Leeds Ave</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-6-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Salem Lutheran</u>		LOCATION (City, town, or county) <u>Catonsville</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>2-5-51</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR <u>Easton Jones</u>		ADDRESS <u>Catonsville Md</u>	

290 246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1350

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore,</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Wood</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mercy Villa</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Ella</u> (Middle) <u>I.</u> (Last) <u>Veasey</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>6,</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>11/7/62</u>
9. AGE last birthday <u>88</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pocomoke City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elijah Scott</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tilghman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>George Dexter</u>		7 Longwood Road	

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

5 years

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diabetes Mellitus

5 years

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1945, to Feb. 6, 1951, that I last saw the deceased

alive on Feb. 6, 1951, and that death occurred at 7 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John M. Scott

8 Longwood Road, Baltimore, Md. Feb. 6, 1951

#### 23. BURIAL, CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

#### (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

#### 24. FUNERAL DIRECTOR

#### ADDRESS

2-7-51

L

John O. Mitchell & Sons, Inc.-1900 Eutaw Place

VVVVVVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>232 Glenmore Ave.</u>		STREET ADDRESS (If rural, give location) <u>232 Glenmore Ave.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary Louise Volz</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 25/51</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>April 24, 1863</u>
9. AGE last birthday <u>87</u> yrs.		10. If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm. F. Menke</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Geo. M. Volz, 232 Glenmore Ave.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

72 hrs

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio sclerosis, generalizedUnknown11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing deathSenility

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 6, 1950, to Feb 25, 1951, that I last saw the deceased alive on Feb 24, 1951, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb. 28/51</u>	<u>London Pk.</u>	<u>3801 Frederick Rd.</u>	<u>Balto. Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/27/51</u>	<u>V.E. Harry</u>	<u>Harry J. Ritzke</u>	<u>4101 Edmondson Ave.</u>	



Mr. Magness.

908 Fredk. Rd.

7 X 9 -

464



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1352

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6212 Frederick Rd.</u>		STREET ADDRESS (If rural, give location) <u>6212 Frederick Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Ada</u> (First) <u>Louise</u> (Middle) <u>VonKennen</u> (Last)		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>1st</u> (Year) <u>1951</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Apr. 1, 1882</u>
9. AGE last birthday <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Duties</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Henry Evans</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Benj. Wellborn 6212 Frederick Rd.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>1 day</u>
Antecedent cause(s) (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u>		<u>10 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-11-1943, to 2-1-1951, that I last saw the deceased alive on 2-1-1951, and that death occurred at 11:40 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>2-5-51</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	LOCATION (City, town, or county) <u>Balto.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>2/5/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Adams</u>	24. GENERAL DIRECTOR <u>Fred. A. Cole</u>		ADDRESS <u>1913 W Balto. St</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 98

1353

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
TOWN <u>2904 GARNET RD</u>		TOWN <u>2904 GARNET RD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>CHARLES D. WAGNER</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>3/20/1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE SHAPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Machine Work</u>	9. AGE last birthday <u>82</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE WAGNER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH GREEN</u>	
15. WAS DECEASED EVER IN U.S./ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-09-3866</u>	
17. INFORMANT <u>MRS WM QUATMAN</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral thrombosis</u>		<u>6 weeks</u>
Antecedent cause(s) (b) <u>Chronic myocarditis</u>		<u>2 years</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 8, 1951, to Feb. 19, 1951, that I last saw the deceased alive on Feb. 19, 1951, and that death occurred at 8:25 P.m., from the causes and on the date stated above.

SIGNATURE Michael L. DeVincentis, M.D. (Degree or title) ADDRESS 11 E Chase St. DATE SIGNED Feb. 21, 1951

23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>2/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM.</u>	LOCATION (City, town, or county) <u>BALTIMORE Co</u> (State) <u>MD.</u>
DATE REC'D BY LOCAL REG. <u>2/21/51</u>	REGISTRAR'S SIGNATURE <u>A. M. Bacon</u>	24. FUNERAL DIRECTOR <u>Charles H. Green &amp; Son Inc</u>	ADDRESS <u>118 W. Mt Royal Ave 544-358</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. DI VINCENTIS MAR 8902



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>Route 1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ARTHUR</u> (Middle) <u>R.</u> (Last) <u>WAGNER</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-25-93</u>
9. AGE last birthday <u>57</u> yrs.		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Reserve Commission</u>	
11. BIRTHPLACE (State or foreign country) <u>Lykens, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ferdinand Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Moser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war, or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) MYOCARDIAL INFARCTION DUE TO CORONARY ARTERIOSCLEROSIS Recent.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)   (c)   II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY  
m.INJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 13, 1951, to Feb. 16, 1951, and that death occurred at 12:40 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND2-16-51

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FURNERAL DIRECTOR

ADDRESS

Singleton Funeral Home200 Crain HighwayGlen Burnie, Md.515916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
FEB 20 1951  
BUREAU



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u> TOWN <u>Fort Howard, Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) _____ OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>600 Brice St.</u>	
3. NAME OF DECEASED (Type or Print) <u>CURTIS, E. WALLACE</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-4-24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X. S. Don't</u>	9. AGE last birthday <u>26</u> yrs. <u>19</u> months <u>16</u> days <u>16</u> hours <u>16</u> min.
11. BIRTHPLACE (State or foreign country) <u>Spartanburg, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kermit Foster</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Dandy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-2</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause (a) <u>Tuberculosis of spine, active</u>  Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____	INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs. plus</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify) _____ TIME (Month) (Day) (Year) (Hour) (Minute) _____ INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	PLACE (Home, farm, factory, street, OF office hldg., etc.) _____ INJURY _____ HOW DID INJURY OCCUR? _____

22. I hereby certify that <u>VA</u> attended the deceased from <u>Aug. 10</u> , 19 <u>49</u> , to <u>Feb. 16</u> , 19 <u>51</u> , that I last saw the deceased <u>alive on</u> and that death occurred at <u>8:28 P. m.</u> , from the causes and on the date stated above. SIGNATURE _____ (Degree or title) _____ ADDRESS _____ DATE SIGNED <u>2-17-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>Feb 23, 1951</u> NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Ft. Myer, Va.</u> LOCATION (City, town, or county) _____ (State) _____	
24. DATE REC'D BY LOCAL REG. <u>2/20/51</u>	24. FUNERAL DIRECTOR ADDRESS <u>Katie R. Wans. 322 N. Schroeder St. Balto. Md.</u> <u>Mrs Katie R. Williams 322 N Schroeder St Balto Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1355

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u> LENGTH OF STAY (in this place) <u>1 year 2 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>		STREET ADDRESS (If rural, give location) <u>5518 Wayne Dr</u>	
3. NAME OF DECEASED (Type or Print) <u>Irene</u> (First) <u>Harfield</u> (Middle) <u>Harfield</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb</u> <u>26</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 31-1864</u>
9. AGE last birthday <u>86</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Church Organist &amp; Choir Director</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Harfield</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Garrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>10-45-00000</u>	
17. INFORMANT AND ADDRESS <u>Laura M. Schroeder, Masonic Home</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
4500 Immediate cause (a) <u>Heart failure due to</u>		19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
97 Antecedent cause(s) (b) <u>Generalized Arterio Sclerosis</u>			
(c) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April, 1949, to Feb. 26, 1951, that I last saw the deceased alive on Feb. 26, 1951, and that death occurred at 10:45 a.m., from the causes and on the date stated above.

SIGNATURE Walter T. Lees ADDRESS M.D. Cockeysville Md. DATE SIGNED 2/26/51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>2/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery Baltimore</u>	LOCATION (City, town, or county) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>2/26/51</u>	REGISTRAR'S SIGNATURE <u>Laura M. Schroeder</u>	24. FUNERAL DIRECTOR <u>Sam. Cook</u>	ADDRESS <u>St Paul &amp; Preston St</u>

057896

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1357

38

Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY <u>BALTO.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO CO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BALTO CO</u>		STREET ADDRESS (If rural give location) <u>3220 Willoughby Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LOUIS</u>	(Middle) <u>B</u>	(Last) <u>WHEELER</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 2 - 1896</u>
			9. AGE last birthday <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Black &amp; Decker Co</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO. CITY, MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>CLAYTON WHEELER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA M SHAFER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>World War I</u>		17. INFORMANT <u>Mrs. Louis B. Wheeler 3220 Willoughby Rd</u>	
16. SOCIAL SECURITY No. <u>216-10-3549</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Heart disease, vascular, coronary, with occlusion</u>			<u>Sudden</u>
(b) <u>Chronic myocarditis, with hypertrophy</u>			<u>Unknown</u>
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Rollin C. Hudson M.D., D.M.E.</u>		DATE SIGNED <u>4/17/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Long Green Cem</u>	
DATE THEREOF <u>2/20/51</u>		LOCATION (City, town, or county) <u>BALTO. CO MD</u>	
DATE REC'D BY LOCAL REG. <u>2-19-50</u>		24. FUNERAL DIRECTOR <u>Larsen Funeral Home 7401 Belair Rd Balto</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>214 Old Battle Grove Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDWARD</u>	(Middle) <u>D.</u>	(Last) <u>WOOD</u>
4. DATE OF DEATH	(Month) <u>February</u>	(Day) <u>12</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-2-91</u>
9. AGE last birthday <u>60</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Policeman</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Wood</u>		14. MOTHER'S MAIDEN NAME <u>Clara Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>216-24-4053</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CORONARY OCCLUSION

INTERVAL BETWEEN ONSET AND DEATH

5 days

Antecedent cause(s)

(b) ARTERIOSCLEROTIC HEART DISEASEUnknown

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb. 9, 1951, to Feb. 12, 1951, and that death occurred at 9:25 A.m., from the causes and on the date stated above.

SIGNATURE Irving Freeman (Degree or title) ADDRESS DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 2-12-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>2/15/51</u>	<u>Oak Lawn</u>	<u>Baltimore</u>	<u>MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/14/51</u>	<u>John H. Hedrick</u>	<u>Howard Blight Funeral Home</u>	<u>6009 Harford Rd., Baltimore, Md.</u>	

Don Mrs Mildred J. Blight 713 936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1359

## 1. PLACE OF DEATH:

County BALTIMORE  
 City or town Bundack  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Balt.  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 140 Aron Beach Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

May Young  
 4. Sex F 5. Color or race col 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Robert Young

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1883

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Cambridge Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Joseph Collins13. Birthplace Cambridge Md14. Maiden name May15. Birthplace Cambridge16. Informant Sadie ChaseAddress 2127 McCulloch St17. Burial Date thereof Feb 24/51  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Int Auburn CemeteryLocation Westport Md.18. Funeral director Mrs. Ethel E. Elliott & SonsAddress 1129 N. Caroline St19. February 24, 1951 R. Williams  
 (Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-51 19\_\_\_\_, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-51 19\_\_\_\_, to 2-21-51 19\_\_\_\_  
 and that I last saw her \_\_\_\_\_ alive on 2-21-51 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Due to usual

\_\_\_\_\_

Due to usual

\_\_\_\_\_

Other conditions none493

(Include pregnancy within 3 months of death)

109

Major findings of operations \_\_\_\_\_

\_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

\_\_\_\_\_

23. SIGNATURE Arthur L. Morris M.D.

M. D. or other \_\_\_\_\_

Address 423 Law M.D. TownDate signed 2-22-51



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Northshire</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Northshire</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7617 Maple Rd.</u>		STREET ADDRESS (If rural, give location) <u>7617 Maple Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First)	<u>GEORGE</u> (Middle)	<u>ZIMMERER</u> (Last)	4. DATE OF DEATH (Month) <u>FEB.</u> (Day) <u>16</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>SEPT. 22-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Continental Can Co</u>	9. AGE last birthday <u>60</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lang</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If year, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>215-05-5986</u>	
17. INFORMANT <u>Mrs. Ida Zimmerman</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Bronchiogenic Carcinoma Left lung</u>		
Antecedent cause(s) (b) <u>with metastases to liver.</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 30 Dec., 1950, to 16 Feb., 1951, that I last saw the deceased alive on 15 Feb., 1951, and that death occurred at 2 A. m., from the causes and on the date stated above.

SIGNATURE Bert Doucet (Degree or title) M.D. ADDRESS 2900 Dunbar Rd Dundalk md. DATE SIGNED 17 Feb 51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-19-51</u>	<u>Sacred Heart Cem.</u>	<u>Dundalk, Balto., Co. md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2/17/51</u>	<u>[Signature]</u>	<u>John G. Connolly - 418 Eastern Ave</u>	<u>1544 34th Balto., 21, md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2900 Dunbar Rd